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Rehabilitation **IN CANADA**



published in the interests of Canada's Disabled by ...

CIVILIAN REHABILITATION

Department of Labour Canada



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CONTENTS

Page

- 3 To our Readers
- 4 A Message from the Minister of Labour
- 5 The New Rehabilitation Act
- 6 The C.M.A. Looks at the New Act
- 7 Federal Participation in Rehabilitation
- 9 General Theory of Low Back Pain
- 13 Emergency Rehabilitation in Morocco
- 15 The National Employment Service
- 16 Technical and Vocational Training
- 17 Report on Rehabilitation
- 18 The World Commission on Vocational Rehabilitation
- 19 A New Member of National Office Staff
- 20 The Division on Older Workers
- 21 Employment Security for Older Workers
- 22 Growth of Services for the Mentally Retarded
- 22 International T.B. Conference
- 23 Society for Crippled Civilians
- 23 C.A.R.S. Mobile Van
- 25 Canadian Conference on Physiotherapy
- 25 School of Rehabilitation Medicine at U.B.C.
- 26 New Books
- 26 New Films

This bulletin is prepared with the cooperation of the Department of National Health and Welfare, the Department of Veterans Affairs, the Unemployment Insurance Commission and governmental and private agencies interested in the rehabilitation of Canada's disabled.

CONTENTS

ROGER DUHAMEL, F.R.S.C.
 QUEEN'S PRINTER AND CONTROLLER OF STATIONERY
 OTTAWA, 1962

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To our Readers . . .

The REHABILITATION BULLETIN assumes a new look with the present issue. In its new form it will now become a seasonal issue and we hope a source of authoritative information on various aspects of rehabilitation.

With the co-operation of specialists the Bulletin will endeavour to fill a growing need for informative articles on the numerous services and disciplines involved in a progressive program of rehabilitation.

This first issue reviews the new legislation which provides a framework for the developing of a bolder pattern of services for the disabled.

With a growing population and the increasing recognition of the rights and privileges of each individual to contribute to the economic and social life of the community it becomes increasingly important to stimulate thought and action to provide the necessary services to enable the disabled to assume the rights and responsibilities of citizenship. We look for the co-operation of all those who work in rehabilitation and the many others who are interested in the welfare of disabled citizens in developing a bulletin truly representative of Canadian interests and programmes. The editorial committee invites your collaboration in making this publication the national organ of rehabilitation in Canada.



A Message from the Minister of Labour

*W*ith this issue, REHABILITATION IN CANADA is making its first appearance in a new and more permanent form, designed to be of more service to its readers.

I think it is appropriate that this should follow closely the proclamation of our new Vocational Rehabilitation of Disabled Persons Act, and the signing of new federal-provincial vocational rehabilitation agreements.

The new Act was drafted very carefully, in consultation with the Department of National Health and Welfare and the Unemployment Insurance Commission. Its aim is to allow us in the Department of Labour to assume our share of federal responsibility in vocational rehabilitation as fully as we can.

Within the total, broad concept of rehabilitation we hope that the new agreements will help to ensure the proper assessment of disabled Canadians and the supply of the services they need to restore them to vocational usefulness, either in a job or in the home.

The fact that this new legislation is not introducing any radically new concepts of rehabilitation can

be taken as a sign that our program has been operating on a sound basis. It could hardly be otherwise, because it is built on the experience of many individuals, and many agencies, public and private, and it is tailored to Canadian conditions.

The vocational rehabilitation program has made steady progress, year by year, and the development of effective administrative procedures is no small part of that progress. We must try to ensure that administrative difficulties never stand in the way of the vocational rehabilitation of any man or woman.

I would like to make this an opportunity to extend my appreciation and thanks to everyone in Canada who is working for the handicapped. We are developing here a system which will be second to none in the world.

There is no work more important, and I feel strongly that it is this kind of concern about its less fortunate citizens that is the mark of truly civilized country.

We can all take pride in the work which you are doing and in the increasing success of your efforts.

MICHAEL STARR,
Minister of Labour.

THE NEW VOCATIONAL REHABILITATION ACT

The national rehabilitation program took another step forward with the passing on May 1, 1961, of a new Act, which will be known officially as The Vocational Rehabilitation of Disabled Persons Act.

This act will govern the Department of Labour in providing its share of federal assistance to rehabilitation. It authorizes the Minister of Labour to enter into agreements with the provinces which will allow the federal government to share, on a 50 - 50 basis, in the costs of comprehensive provincial programs of vocational rehabilitation.

This, on the face of it, does not seem new, for the federal government is already contributing to well-established rehabilitation programs in all provinces. These agreements came into effect on April 1, 1962.

However, the agreements under which the provinces operated were authorized by Order-in-Council and funds were made available by an annual vote of Parliament. Now, the new act provides statutory authority for the program and authorizes the Minister of Labour to enter into agreements with the provinces for a period of six years.

The purpose of this change is to clarify federal and provincial responsibilities in the area of rehabilitation and, as the Hon. Michael Starr said in introducing the bill in Parliament, "to encourage the provinces to plan ahead in developing more effective rehabilitation services."

On the whole, this act is concerned with *individual* disabled people—it makes it possible for the Department to participate in the rehabilitation of disabled men and women according to their particular needs. Thus, the Department can contribute 50 per cent of the cost of any services or treatment, not available from other sources, that a disabled person needs to go as far along the road to gainful employment and a full life as his condition permits.

Agreements are being worked out between the federal government and the individual provinces.

As set out under the Act and the agreements, a comprehensive rehabilitation program includes the following areas, in all of which the federal government will share half the cost of providing services.

Assessment, and Counselling of Disabled Persons

This means assessment of a kind which will determine whether or not the disabled person can be

accepted for vocational rehabilitation services. Three aspects of assessment are specifically covered. Medical assessment determines a person's loss, the capacities he has left and possible remedial action. Social assessment determines his personal resources or deficiencies in relation to his work, his family and his personal relationships. Vocational assessment evaluates the persons' potential in relation to the jobs which would be available to him.

Restoration, Training and Employment Services

These are the services and processes designed to enable a handicapped person to become vocationally useful, on the job or in the home.

The cost of providing restorative treatment or prosthetic appliances, as indicated by assessment of a disabled person, can now if necessary be borne under the terms of the act.

It is understood that full use will be made of services already available to the general public without charge; including services provided through the Hospital Insurance and Diagnostic Services Act.

Vocational training can be secured for disabled persons as provided for in federal-provincial agreements under the Technical and Vocational Training Assistance Act. Such training was of course available before the passage of the new act.

The National Employment Service will continue to accept responsibility for finding jobs for rehabilitated persons, who are considered capable of performing satisfactorily in the regular competitive labour market.

The National Employment Service will also continue to give technical assistance in vocational assessment and in the development of vocational rehabilitation plans for individual disabled persons.

In all phases of the rehabilitation process, the provinces make full use of the services offered by the private voluntary agencies. Sometimes such an agency is designated by the province to provide vocational rehabilitation services on an official basis, and in cases such as this the federal government will pay half the cost of such services.

Provincial Co-ordination and Provincial Programs

The agreements will continue, and widen, the assistance available to prov- [Continued on Page 6]

THE C.M.A. LOOKS AT THE NEW ACT

The following is reprinted from the Journal of the Canadian Medical Association:

Few practising physicians would disagree with the observation that "... under present provisions, securing the various services necessary to the vocational rehabilitation of the disabled can be a baffling and time-consuming process" as stated recently by the Honourable Michael Starr, Canada's Minister of Labour. While this is hardly so in the case of disabled veterans, industrial accident victims and a few other categories of physically handicapped persons, doctors are frequently confronted by the problems of disabled people for whom there seems to be no authority responsible for providing the comprehensive medical, social and vocational rehabilitation services which they need. The importance of solving this problem has been discussed previously in the editorial pages of this journal.

Mr. Starr's comment was made during the House of Commons debate on the new Vocational Rehabilitation of Disabled Persons Act. This measure appears designed to correct the situation, at least in so far as this lies within the competence of Parliament.

The Act authorizes the Minister to make agreements to pay 50% of the costs incurred by any Province in providing a comprehensive program for the vocational rehabilitation of disabled persons. Earlier measures, such as the Medical Rehabilitation Grant, placed ceilings on the Federal Government's financial participation in rehabilitation programs. These restrictions tended to discourage action by Provincial Governments. The new Act sweeps these impediments aside.

The Act will not, by its mere existence, automatically achieve the Federal Government's high purposes. It places the onus squarely on the provinces to determine what comprises a comprehensive program for the vocational rehabilitation of disabled

persons. Ultimate success in this endeavour will depend largely upon the initiative, vision and vigour displayed by the provinces, but it may be hoped that the Federal Government will decline to make agreements with provinces proposing anything less than the comprehensive program which the Act calls for.

The Act provides that a comprehensive program of vocational rehabilitation may include "services and processes of restoration", and that its objective is to enable disabled persons to become capable of pursuing regularly "a substantially gainful occupation". Should a narrow construction be placed on either of these terms, there is danger that essential medical and surgical procedures may not be included, and that housewives and others, whose rehabilitation objectives do not embrace remunerated employment, may be excluded from assistance.

The complex problems presented by the disabled rarely conform to the neat functional distribution of responsibilities among government departments. The baffling process which Mr. Starr refers to is likely to be perpetuated at the provincial level unless responsibility for each provincial rehabilitation program is concentrated in the hands of one Minister and one department. This is necessary for effective leadership and improved co-ordination of the related activities of other government departments and voluntary agencies. A study of the system whereby the Department of Veterans Affairs assumed total responsibility for the rehabilitation of disabled veterans and yet achieved a high degree of participation by other governmental and voluntary agencies should prove illuminating for those responsible for planning the expanding rehabilitation programs envisaged under the new Act.

[Continued from Page 5] inces for the cost of salaries and travelling expenses of Provincial Coordinators and their staffs, and of some other expenses incurred in the operation of provincial rehabilitation programs.

The agreements provide for the training of counsellors or administrators employed in provincial rehabilitation programs, or in agencies designated by a province to carry out a particular part of its program. The cost of training can include tuition,

transportation, books and equipment, and living expenses.

Federal assistance under the Act is also available for other purposes such as provincial research projects.

The agreements and their schedules will clarify the ways in which governments and private agencies can work together in the most effective way for the benefit of the disabled.

FEDERAL PARTICIPATION IN TREATMENT FOR REHABILITATION

A review of health grants,
hospital insurance and vocational
rehabilitation legislation as related
to the provision of restorative services
to disabled persons

By B. PRIMEAU, M.D., M.P.H. *former Medical Consultant and
Chief of the Medical Rehabilitation and Disability Advisory
Service, Department of National Health and Welfare.*



In 1948, within the comprehensive National Health Grants Program, the Crippled Children Grant was provided to assist in an extended program for the prevention and treatment of crippling conditions in children, including rehabilitation and training;

In 1953, the new Medical Rehabilitation Grant was introduced to fill in the gaps which existed in the National Health Program in so far as the provision of assistance for rehabilitation services was concerned;

In 1957, the Hospital Insurance and Diagnostic Services Act made provision for contributions to the provinces with respect to the cost of insured services, which are defined to mean both in-patient and out-patient services to which residents of a province are entitled under provincial law;

In 1960, the rearrangement of the National Health Grants Program resulted in the Medical Rehabilitation and Crippled Children Grant designed to assist in approved programs for the prevention, treatment and medical rehabilitation of crippling conditions of children and adults;

In 1961, the Vocational Rehabilitation of Disabled Persons Act authorized agreements with the provinces to provide for the payment of contributions in respect to the costs incurred by the province in undertaking a comprehensive program of restoration, training and employment placement, to enable a person physically or mentally impaired to become capable of pursuing regularly a substantially gainful occupation or to dispense with

the necessity for institutional care or the necessity for the regular home services of an attendant.

What are, for the rehabilitation workers at the provincial level, the implications of these above mentioned progressive developments, which have improved, during recent years, the general formula of available assistance offered at the Federal level for the establishment, operation and expansion of provincial rehabilitation programs and for the increased comprehensiveness and efficiency of rehabilitation services available to disabled Canadians?

The Medical Rehabilitation and Crippled Children Grant

The Medical Rehabilitation and Crippled Children Grant, within its present terms of reference and desirable application, remains available for:

(a) The training of medical and para-medical personnel to be employed in the field of medical restoration; this training assistance may be in the form of financial help offered under the Grant to the professional schools established for the training of both under-graduate and post-graduate students in the various medical restoration disciplines, or in the form of bursaries granted to individual students.

Training is also available for both short-term refresher courses and long-term diploma or degree courses. In relation to hospital staffs, every province has the choice of deciding between the continuation of bursary assistance under the

Health Grants, and the inclusion in the shareable operational costs of hospitals of the expenditures involved in supporting students among the staff already employed or recruited for a prospective assignment.

(b) The purchase of physical medicine equipment related to medical restoration programs operated for the benefit of out-patients in centres outside of hospitals;

(c) The establishment of new or the expansion of already existing medical restoration facilities and their maintenance outside of hospitals; and in organized out-patient hospital departments; such assistance may be in the form of sharing of salaries for staff employed in out-patient rehabilitation centres, and in organized out-patient hospital departments, in those provinces in which out-patient services are not yet insured services under the Hospital Insurance Agreement, and also in the form of sharing the fees paid by a hospital for the clinical work of a physiatrist, since medical care services are not insured services under the Act; it should also be remembered that financial assistance can be requested and approved for both equipment and staff related to the organization and maintenance of community programs of home care.

(d) The purchase of medical restoration services for the benefit of patients treated on an out-patient basis, in both outdoor rehabilitation centres and organized out-patient departments of hospitals, in those provinces in which out-patient services are not insured services under the agreement, when these patients are unlikely to engage in gainful occupations or to be restored to self care;

(e) The development of research in the field of medical restoration.

The Hospital Insurance and Diagnostic Services Act

The Hospital Insurance and Diagnostic Services Act, makes assistance possible towards:

(a) The use of physiotherapy facilities where available; "physiotherapy facilities" is here an all inclusive term for medical restoration facilities which are insured services under the Hospital Insurance Plan;

(b) The purchase of physical medicine equipment related to hospital departments of medical restoration;

(c) The salaries of staff employed for the medical restoration of hospital in-patients, and of hospital out-patients in provinces in which out-patient services are insured services under the Hospital Insurance Plan;

(d) The part of the salary of a physiatrist which corresponds to his administrative responsibilities concerning the organization and direction of the hospital physical medicine department.

The Vocational Rehabilitation of Disabled Persons Act

The Vocational Rehabilitation of Disabled Persons Act, authorizes the sharing of costs incurred in providing:

(a) Assessment and counselling services for persons who because of physical or mental impairment are incapable of pursuing regularly a substantially gainful occupation.

(b) Services and processes of restoration, training and employment placement designed to enable a disabled person to become capable of pursuing regularly a substantially gainful occupation or to dispense with the necessity for institutional care or the necessity for the regular home service of an attendant.

On the whole, the final result of the working interrelationships which should be maintained between all these plans orientated towards the same goals should be practically translated in a more adequate and more comprehensive satisfaction of all the different needs discovered through the individual assessment of every disabled person.

Wanted

Proceedings—CONFERENCE on the REHABILITATION of the PHYSICALLY HANDICAPPED—Held in Toronto, February 1, 2, 3, 1951,—Under the Auspices of the Department of Labour; the Department of National Health and Welfare; and the Department of Veterans Affairs.

Requests for this publication have been received at this office but the supply is exhausted. If anyone has a copy which can be spared please send it to CIVILIAN REHABILITATION, DEPARTMENT OF LABOUR, OTTAWA. Your assistance in meeting this need will be much appreciated.

GENERAL THEORY OF LOWBACK PAIN

—as applied to the social question
of physical fitness, prevention
and treatment—a unity

By FREDERICK SYPHER, B.A., M.D., F.R.C.S.(Can.), F.I.C.S.

A very large proportion of persons needing rehabilitation services fall within the group presenting musculoskeletal problems, and pain in the back is a common symptom.

Dr. Sypher, in a previous article entitled "Pain in the Back: A General Theory" which was published in the Journal of the International College of Surgeons, Vol. 33, No. 6, June, 1960, presented a theory as to causes, diagnosis and treatment of conditions associated with pain in the back, pointing out that faulty adaptation to the upright posture is capable of producing a wide variety of skeletal problems based on abnormal muscle tension. A small added stress may produce a disproportionately severe reaction. In Dr. Sypher's experience, treatment based on this general theory has given surprisingly good results.

A second article is here presented in the hope that it will stimulate further thinking as to ways and means of dealing with this all too common disablement.



Dr. Frederick Sypher, a graduate of the University of Western Ontario, served with a specialist orthopaedic unit organized in Canada by the Red Cross to serve various branches of the British Armed Services in Scotland from 1943 to 1945. Following a short period as orthopaedic specialist at Westminster Hospital in London, Ontario, he worked under the auspices of UNRRA at the National Chung Cheng Medical College, Kiangsi Province, China, establishing an orthopaedic service and acting as lecturer to final year students in the field of orthopaedic and traumatic surgery.

On his return to Canada he became Consultant to the Workmen's Compensation Board of Ontario.

Before setting up in private practice as a specialist in Orthopaedic and Accident Surgery he worked for a time with Dr. H. Hoyle Campbell doing reconstruction surgery on hands and peripheral nerves.

If the theory I presented in my article "Pain in the Back" appears to be reasonable, then certain implications regarding prevention and treatment of back pain should be accepted. Some further comment is required concerning these implications, and their relationship to physical fitness in general, as a sociological problem. These days there is much concern expressed in many quarters, reiterated recently by national leaders in Canada and the United States, that standards of physical fitness are deteriorating to a very dangerous degree. The increasing economic loss, not to mention pain and suffering, is well recognized, but not so well recognized in the necessity of a *fresh approach* to the whole problem.

The article referred to gives a new theoretical orientation to back pain and related muscle tension

phenomena; it indicates that individual symptoms devolve from a society where many pressures are conspiring to produce abnormal strain on weight-bearing joints, and that such strain, operating over long periods, sets up a process of abnormal wear, which together with the body's reaction to it, accounts for the clinical picture in different stages of the process. The article emphasizes the importance of the recurrence aspect of low back pain, it presents an explanation of the periods of remission of symptoms, and points out why one person with abnormal body mechanics may go along for many years with little or no symptomatology, while another similar case, with less apparent provocation, breaks down. Also, it appears logical that symptoms need not correspond, necessarily, to the severity of the underlying disease process.

Classification—Not Based on Former Clinical Entities

This new Theory has been the basis of my treatment of private patients for a number of years, and it was soon found to require a qualitatively different classification. I now think of the following factors in setting up a code for the filing of cases:

1. General mechanical stress;
2. Stage of process and various triggers capable of precipitating symptoms;
3. Diffuse or localized reaction to stress;
4. General anatomical regions (between fixed and movable segments of spine) where stress and strain is particularly focused.

Without going into the details of this form of classification at the present time, the point may be illustrated by considering spondylolisthesis as a condition which simply adds instability to the lower lumbar spine, increasing its susceptibility to mechanical stress of the individual's own weight, plus whatever he happens to be carrying. This focus, under muscle support, with a normal line of weight bearing and habits of action which build up reserve in muscles, is in itself of no significance, and need not necessarily appear in the classification code. The presence of this condition might become important if the patient sought advice on the question of changing his job—say, from taxi driver to acrobatic dancer—but under most circumstances, it has minimal influence on my methods of treatment.

Similar reasoning may be applied to disc lesions associated with specific nerve root pressure syndromes. I am not concerned that a patient has "a disc lesion", because I know that with appropriate rest and positioning, he will rapidly be free of pain, and that other symptoms will gradually subside. Moreover, the methods of rest and graduated activity are the re-education, or rather the tools to be used by the patient in making the correct adaptation to the upright posture. He is therefore not wasting time; his treatment from the first day is also his re-education, and at the same time, his new habits are his assurance against recurrences.

Techniques of Treatment

In the article on theory, I did not go into specific methods of treatment. This is hard to do, because no two cases are exactly alike in the application of the Theory—body build, the stage of the underlying process, occupation, emotional factors,

history of specific disease, all require variations in the way fundamental principles are applied. The basic principles on which the Theory rests do not, of course, change from case to case. The principles are applied in terms of the particular activities of the individual, with the activities becoming, in themselves, a treatment. There is a right way and a wrong way to use the body in any given action, so that, in the process of treatment, bad habits are replaced by good ones, with normal muscle balance being consolidated. When these new habits, in reference to the patient's routine activities, become automatic, the patient can go on building up resistance against recurrences, without any conscious effort. This may be likened to learning a language; one learns certain basic vocabulary, and finally speaks the new language unconsciously. When one can recognize the simple basic principles of correct body motion in such apparently diverse actions, as, for example—shovelling snow, playing tennis, bowling, painting the ceiling,—one can continue to add activities as one continues to build up the reserves of weight-bearing joints and the power in the muscles which control them. Otherwise, the reserve of a joint diminishes, the fatigue correspondingly increases, and decompensation finally occurs. That is, joints improperly stabilized by abnormal muscle balance exceed their tolerance, and inflammatory reaction, with varying degrees of degenerative change, supervenes.

If a person continued to play cowboys and Indians instead of watching the spectacle on TV, nature would spontaneously maintain joints in normal muscle balance provided loads were commensurate with power—that is, with control of the joints. But, the pressures of civilization offset the natural adaptation until chronic abnormal stress insidiously makes its demand for a different adjustment to weight-bearing stress. Muscle imbalance is compensated by abnormal stress on joints, so that this different adjustment, though faulty, serves until joint reserve has diminished to the threshold level. It is surprising, even after years of faulty weight-bearing habits, how rapidly nature returns one to normal if given a reasonable opportunity.

Treatment and Prevention—A Unity

This treatment boils down to the simple proposition that any person, in doing what he normally does each day, must do it correctly,—with good habits of body mechanics. It is seen that

Treatment and Prevention are now essentially one and the same thing, demanding a social approach to individual problems.

I have carefully considered the application of this Theory to group problems of prevention-treatment. This unity, which is an aspect of the social process, involves two main groups, according to the *presence* or *absence* of decompensation of the musculo-skeletal system. Where decompensation has not occurred, one takes a group in a factory or other institution, such as a school, and one uses any education devices such as movies and demonstrations to give a simple orientation to general theory. More particularized supervision is then given in different job categories, and finally individuals who, in spite of this program, are showing signs of decompensation are given special assistance in the correction of faulty body mechanics.

In the decompensation group, such as could be encountered in a rehabilitation centre, all members would be started out in similar rest positioning, which I refer to as "Rest and Variations", until acute inflammatory reaction subsided. Each individual would proceed, at his appropriate rate, toward increased activity by applying basic principles to gradually increasing activity—lying, sleeping, standing, walking, etc. being the tools of individual treatment. Group practice sessions would be organized at timely intervals for those at a given stage of re-education, but it will be appreciated that such groups conform, not to the diagnoses of specific lesions, but rather to the factors which account for the variations in susceptibility to decompensation. These have already been mentioned: body build, stage of process, occupation, etc.

Individuals in whom decompensation has not occurred, may be considered broadly as under preventive therapy. Yet the general approach, whether decompensation has occurred or not, is uniform, consisting of general orientation, group peculiarities, and individual peculiarities. With proper theoretical orientation, the group treatment does not enforce any conformity on the individual, but only provides a motivational framework for greater individual expression, so that volume handling does not sacrifice individual values. The concept of normal may now be achieved, not as an idealistic abstraction in the manner which pertains at present, but rather as an individual reality, conforming to the social necessities of the individual.

The Best Test of a Theory

There is no doubt in my mind as to the validity of this approach to the diverse manifestations of faulty weight-bearing dynamics, but it can easily be tested. Take the problem group of low back pain cases in any rehabilitation centre, continue to treat half of them in the conventional way, and let me treat the other half in conformity with the General Theory. Reassess after three months, and at longer intervals as may be designated. Recurrence rates, which are of the greatest importance, can be compared.

It is granted that "backs" represent a serious and urgent social problem. Centres now coping with these cases should, I think become aware of the new approach, and that my services are available. The centre most perceptive of the General Theory should have first claim on my assistance. I would stay long enough to get a program established, and train one or two of the personnel—say a doctor, and a technician. I would like to see programs based on the General Theory not only in rehabilitation centres, but also in schools, and industrial and other institutions.

Failure of Traditional Methods

It is difficult to find any point in pursuing traditional methods where "prevention" and "treatment" represent closed compartments, with neither one being of much social value. It is futile, for example, to tell a person to "exercise". No one but a fanatic will persist for any length of time on a regular exercise routine. Occasional exercise may easily be worse than none at all, since it may only serve to produce additional strain in joints which are already stressed nearly to the symptom threshold, simply by the faulty mechanics of merely standing. Reaching out with an arm, in the presence of inability to stabilize the lumbar spine, may trigger a severe reaction, provided the stage is already set by faulty adaptations, and this may occur even though the individual has not suffered any serious episodes of back pain in the past.

People whose reserves are seriously impaired usually have the good sense, at any rate after a trial or two, to avoid exercise routines which are put out for mass consumption. The present, unwitting tragedy appears to be the necessity of attempting to promote "prevention" purely as a mass mechanism, or alternately, of treating specific lesions in a piecemeal fashion. Both processes are obviously dehumanizing, and anti-scientific.

The traditional handling of "back pain" may be reviewed as follows; Cases in the early reactive stage, most of which get better with, without, or in spite of treatment, are stalled along from one episode to another by a series of "Grandmother Remedies" of one kind or another, plus plain pills, tranquilizers, etc., until they enter the corset-bracing period. Now, quite dizzy from shuttling back and forth between the general practitioner, specialist and chiropractor, they may encounter the psychiatrist. A certain percentage finally achieve specific lesions, for which operations have been described—a worn knee may give out, or a "disc" may "blow out". Rehabilitation centres keep labelling the patient "fit for lighter work", until activity finally diminishes to a point incapable of provoking symptoms. The patient has no symptoms now, so he may be considered "cured" at last!

This slight exaggeration is not meant to imply that palliation has no place. Just as a patient with serious heart disease may carry through a long life on nitroglycerine, so a patient may, under certain circumstances, be assisted in carrying on with habitual postural adaption which may be faulty, but may be considered acceptable in terms of the patient's particular needs. If this course is followed deliberately, and with understanding, it is one thing, but it is quite another if followed through ignorance.

General Theory in Private Practice

In applying the methods of treatment based on General Theory to private patients, I am agreeably surprised at the ease with which most of them, in a general way, grasp the nature of their problems. The more severe the problem, the better is patient co-operation; these cases have almost always had previous episodes of some severity, and the contrast in methods used impresses them most favourably. Patients in whom emotional components in muscle tension problems run high are more variable in acceptance, particularly if they do not get support from their family doctors. This is mainly because, at times, there may be some temporary reactivation of symptoms, even though the general trend of improvement is steady.

It has now been several years since I have found it necessary to hospitalize a patient for back pain

in statistically determined conditions, including full blown disc lesions. If the stage of the underlying process warrants it, the patient must initially be seen at home. The stress of getting into a car, and on to an examining table, may be critical, delaying recovery by several weeks. The patient must be supervised several times during the first month, and then at less frequent intervals as his capacity for applying good habits of body mechanics to routine activity improves. Many other patients, depending on the stage of the process involved, may merely require a tip or two concerning a better adaptation of body mechanics to their particular job, necessitating only a single visit to the office. Although fundamental principles are constant, no two patients can ever be treated exactly alike; the timing of change from horizontal to upright adaptations varies with the individual, which in turn depends on a variety of factors. The date of return to work depends on the extent to which work activities may be utilized in muscle re-education. With increasing experience in the application of the General Theory, one can, with ever-increasing accuracy, predict the patient's course, and chances for recurrences. This does not hinge critically on the so-called entities, e.g., fibrositis, osteoarthritis, spondylolisthesis, disc disease, anatomic variations, and so on, but rather on the opportunity and capacity for the patient to discard improper weight bearing habits while learning to apply normal body mechanics to routine activities.

Conclusion

Certainly no one who tabulates the results of conventional methods is satisfied with the existing situation, and one is constantly hearing solemn warnings about the general problem of physical fitness. Although the application of the General Theory in private practice is satisfactory, from the standpoint of the individual patient it is not in harmony with the attitudes of the various third parties, which are cast in the traditional mould. The General Theory can only achieve its full promise when it becomes one aspect of the general social process. Maybe one of the centres across the country would like to start the ball rolling on this different approach.

EMERGENCY REHABILITATION IN MOROCCO

By B. PRIMEAU, M.D., M.P.H. *former Medical Consultant and Chief of the Medical Rehabilitation and Disability Advisory Service, Department of National Health and Welfare.*

In September, 1959, a bargain cooking oil appeared on the market in Morocco. The oil was the traditional olive oil, with which had been mixed aircraft engine lubricant containing a small percentage of a highly toxic detergent chemical.

Everywhere it was sold, cases of paralysis appeared in increasing numbers—in a short time, more than 10,000 Moroccan men, women and children had been crippled.

Almost from the beginning, it was apparent to Moroccan authorities that they had a major disaster on their hands, and one which their facilities could not cope with. They turned to the League of Red Cross Societies and the World Health Organization for help and sixteen countries responded.

Canada's contribution was important for several reasons. We were able to send internationally recognized authorities on physical medicine and rehabilitation. These doctors, and the Canadian physiotherapists and nurses, were largely French-speaking. This, and the fact that in a sensitive political situation Canadians were accepted without the suspicion which clouded European-African relations, meant that our representatives were able to do their job with the maximum of efficiency.

Dr. Primeau, the author of this article, was the third Canadian to be appointed by the League of Red Cross Societies and WHO as chief delegate and medical liaison officer to the Moroccan Ministry of Health during the emergency.

In June 1961 an unprecedented medical action was completed in Morocco. Conducted for 18 months, it presented many of the characteristics peculiar to modern large scale treatment programs, made possible in our day and age through very efficiently organized health and welfare agencies and excellent international co-operation.

The greatest number of doctors of physical medicine and physiotherapists ever mobilized for an international operation were required for the Moroccan Rehabilitation Program. Because of the relative scarcity of these specialists, the National Red Cross Societies had to make special request, to hospitals, medical schools and Ministries of Health for the loan of staff who could be freed from duties only for limited periods. This required a nearly continual recruiting effort.

Despite this situation, the Program was set in motion in six weeks time, with 50 doctors, physiotherapists and polio-experienced nurses. An appeal by the League of Red Cross Societies, was launched on 21st November 1959 and the International Rehabilitation Program, under the direction of the Moroccan Government and with the collaboration of the World Health Organization, got under way on 1st January 1960. Administrative staff necessary for the operation of the Centres, together with some 150 Nurses Aides to assist the international medical

and nursing personnel, were provided by the Moroccan Government.

In all, the services of 175 medical and nursing personnel were recruited and provided by national Red Cross and Red Crescent Societies of 16 countries. A minimum value of the composite total of 100 years of service performed by this personnel would be approximately 2,135,000 Swiss Francs. Costs in connection with these personnel, i.e. their travel to and from Morocco, their salaries, and a daily living allowance, was met by the National Societies recruiting them; the Moroccan Government provided board and lodging.

The personnel from National Societies were assigned to teams on a multi-national basis. In their first six weeks, the teams, despite improvised working facilities and language difficulties, and often working in near-freezing weather, examined nearly two-thirds of the paralyzed patients (6,331 men, women and children) as the initial step of the Rehabilitation Program. The total number of patients ultimately registered was 10,466. Of these, 1,844 were children under 15 years of age. The second group, from 15 years numbered 8,662, of whom 60 per cent were women.

An important amount of hospital material was needed to launch the International Rehabilitation Program. The League's initial appeal to member

societies asked urgently, therefore, for 2,400 fully-equipped hospital beds, plus certain amounts of clothing and foodstuffs. Within 45 days, 2,639 hospital beds were contributed and delivered to Morocco; the minimum value placed on this hospital material is 1,365,000 Swiss Francs. Over 100 tons of the 150 total of equipment and supplies was airlifted. The number of transport planes made available—twenty-five—by the air forces of the German Federal Republic, Turkey and the United States was the largest to take part in an airlift organized under League auspices.

Further equipment and facilities including pools for hydrotherapy were subsequently installed by the Moroccan Government in the six Rehabilitation Centres.

The majority of the paralysis victims received treatment on an out-patient basis. A vehicle pick-up service was organized by the Moroccan Ministry of Health for the different Centres; this included staff to carry patients who could not walk to and from vehicles.

A remarkable relationship sprang up between Red Cross medical staff and the victims. As the paralyzed were transferred from one physiotherapist to another for more advanced treatment, the patients insisted on going back to the previous physiotherapists and showing them their progress in gaining further use of hands and feet.

Originally, the League had planned to terminate its participation in the International Rehabilitation Program on 30th June 1960; before mid-1960, however, the Moroccan Red Crescent and Government requested continuation of the League action until the end of the year. In late October 1960, an urgent request was made by the King of Morocco, the late Mohamed V, for the League's further continuation—until 30th June 1961.

Canada's Part

A very special mention should be included here of the outstanding role played from the beginning and until the termination of the program by our Canadian Red Cross Society. As an early reply to the League's call for help, the Canadian Red Cross Society contributed very valuable hospital material for the paralysis rehabilitation program in Morocco. Such items of equipment and supplies were immediately sent to Morocco and in such quantities as 128 cases of sheets, quilts, children clothing and nightgowns, 6,000 pairs of men's and children's socks, 1,156 Junior Red Cross

relief kits and 3 cases of child walkers, parallel bars and crutches.

But the greatest effort of the Canadian Red Cross Society was certainly the one maintained throughout the relief operation by its successful recruitment and its generous loan, at its own considerable expense, of the constantly largest team of physicians and physiotherapists engaged in this international rehabilitation program. One or two specialized physicians and five or six qualified physiotherapists represented Canada on every one of the three teams recruited by the Canadian Red Cross Society during the 18 months of the program—a total of 23 professionals (six physicians and seventeen physiotherapists, including two occupational therapists) between December 27, 1959, and June 30, 1961. The Swiss Red Cross Society was the only one among the 16 countries involved which contributed a larger number of personnel.

Additional comments should also be expressed here on the fact that this very impressive contribution made by the Canadian Red Cross Society was paralleled by a quality of selection of staff which was well recognized and profitably utilized by the officials responsible for the rehabilitation program and of which we were all very proud as Canadians participating in this operation. At the beginning of the operation and at the time of the arrival of the first international teams in Morocco, the League of Red Cross Societies appointed as its Chief Delegate and Medical Liaison Officer with the Moroccan Ministry of Health, Professor Gustave Gingras of the University of Montreal. Two other Canadian physicians succeeded Dr. Gingras in that same capacity of Chief Delegate, Dr. Max Desmarais of Winnipeg and the writer, so that the conduct of the League's program during the first year of the total 18 months' operation was under the direction of a Canadian Red Cross representative.

Moreover, the three other Canadian physicians recruited by the Canadian Red Cross Society were all in charge of a Rehabilitation Centre during their assignment to the Moroccan Paralysis Relief Operation. Finally, a few of the Canadian physiotherapists sent to the program were assigned as Head Physiotherapist of one of the Rehabilitation Centres, in charge of treatments undertaken by the foreign personnel from various countries, and two of our Canadian girls recruited by the Canadian Red Cross Society were later seconded to the World Health Organization as [Continued on Page 27]

THE NATIONAL EMPLOYMENT SERVICE

Its Role in Rehabilitation of the Disabled

By W. THOMSON, Director of Employment Service, Unemployment Insurance Commission.

Every case processed by a rehabilitation service must have as its optimum goal restoration of the individual to the point of self-support, where he or she can make a worthwhile contribution to society and to the economy of the nation. We realize, of course, that this is not always possible, and that there will always be some who, despite the best efforts by all members of the rehabilitation team, will not be restored to the level where they can perform what is usually known as 'a day's work'. Nevertheless, it speaks well for the various provincial programs that the great majority of persons who have received organized rehabilitation services to date have, in fact, become capable of re-entering the labour force. Suitable employment then is the target at which all efforts are directed and the significance of job placement in the overall rehabilitation plan can not be overemphasized. It is in this area—selective placement of the disabled—that the National Employment Service of the Unemployment Insurance Commission makes its major contribution to rehabilitation in Canada.

Since its inception, the policy of the National Employment Service has been to endeavour to refer to suitable employment any resident of Canada, of whatever occupation or calling. Within the framework of this policy, recognition has been taken of the particular needs of smaller groups, among whom are the physically handicapped, and, without prejudicing or restricting the employment rights of other persons, provision has been made to give special assistance to those who require help to secure suitable employment.

This service is provided by staff known as special placement officers. In larger centres, where the volume of work is high, there are separate special placement sections of the National Employment Office. In the smaller centres, officers are identified and trained for the responsibility of providing the specialized help required. In this way, facilities are available at all 200 local offices across Canada. As demands for special services increase, a constantly growing number of offices are being given full-time special placement staff. This policy of expansion of services will continue

as the need is demonstrated.

In considering staffing, however, much more is needed than just plain numbers. Special placements is a technical field which requires that officers be given adequate training to carry on the functions of employment counselling and selective placement. The National Employment Service, therefore, intends, as in the past, to continue to devote considerable attention to staff training by means of university courses developed by English and French speaking universities to our specifications; by area schools for special placement officers held periodically at various centres across the country; and by on-the-spot training sessions which are conducted in all local offices on a continuing basis. In addition, specialists at regional offices provide advice, counsel, and guidance.

This, then, is an outline of how National Employment Service is organized to fulfil its role as the placement agency in the rehabilitation program. It should be borne in mind, however, that NES is not a social agency, but a public employment service charged with the responsibility of finding suitable workers for employers as well as suitable jobs for workers. It is the former responsibility which compels us to refer to employment only those who are physically and mentally capable of performing in competitive employment. We will not attempt to place incapable persons for whom employment depends solely on employer sympathy.

In addition to the placement role, NES assists rehabilitation agencies by advising about employment aspects to be considered when a rehabilitation plan is being developed for an individual. This is actually the function we perform by serving as members of the various training selection committees which authorize training for the disabled. We also aid in evaluating the employability of rehabilitants in relation to occupational demands and current labour market conditions. The many advantages accruing from close liaison between rehabilitation agencies and special placement officers have been amply demonstrated, and we intend to encourage further development along these lines.

[Continued on page 27]

TECHNICAL AND VOCATIONAL TRAINING

The New Canadian Act and Agreement

About a year ago, Parliament passed the new Technical and Vocational Training Assistance Act, to stimulate the development of technical and vocational training programs in Canada and to broaden their scope.

The new Act replaced the Vocational Training Co-ordination Act, which was familiar to many people working in rehabilitation.

In order to fully implement the possibilities of this new legislation, a new federal-provincial agreement has been signed by all provinces and became effective April 1, 1961.

This new Agreement, called the Technical and Vocational Training Agreement, replaced the Vocational and Technical Training Agreement and the Special Vocational Training Projects Agreement which had been in effect for several years.

In particular, Schedule "R" of the old Special Vocational Training Projects Agreement provided specifically for federal-provincial sharing, on a 50-50 basis, of the costs of vocational training for physically handicapped persons with continuing disabilities, who required training or retraining to fit them for gainful employment.

Schedule "R" has come to be an important link in the chain of activities that make up rehabilitation, and it has been carried over into the new Agreement as Program 6.

While the other provisions of the Agreement do not bear so directly on rehabilitation, we all realize the ultimate importance of all kinds of education to the success of rehabilitation. Anything that raises the level of education and training of Canadians generally will be reflected in the qualifications of rehabilitated disabled persons, and is bound to make the task of placing them in employment much less difficult.

For this reason a brief summary of the main provisions of the Agreement should be of interest to readers of "Rehabilitation in Canada".

The following are the most important features of the new Agreement.

First, it provides that the federal contribution to the cost of new facilities, both buildings and equipment, will be increased to 75% of such costs up to March 31st, 1963. After March 31st, 1963 the Act provides for a 50% share of capital costs

without the limit of a quota allotment based on an age group which applied previously. The new facilities include technical and vocational high schools, technical institutes, trade schools, and institutes of technology.

With respect to technical and vocational high schools, the provisions of the Act authorize a continuation of the federal assistance that has been provided for the technical vocational programs which are part of the secondary school system.

Under the new Agreement, an annual allotment of \$3,000,000 is divided among the provinces by allotting to each province \$30,000 and to the Northwest Territories and the Yukon \$20,000 each. The balance of the \$3,000,000 is allocated to the provinces on a basis of the number of young persons in each province as compared with the total number in Canada.

Subject only to the limit of the funds voted by Parliament, the Federal Government will contribute 50% of the provincial government's operational cost of technical, trade or occupational training for all persons who have left the regular school system without the limit of a quota allotment based upon a population group. This is covered in the Agreement as Program 3.

A new feature recognizes the rapidly growing post-high school technical programs which give training in the skills and application of science and technology, to train the technicians who are so essential in our developing industrial economy. The Federal Government will contribute 50% of provincial expenditures on the operation of this program which is covered in the Agreement as Program 2.

A very important new provision will make it possible to develop strong technical vocational programs, for it provides for the training of the teachers, the supervisors and administrators, who will be required to direct, supervise, and give instruction in the expanding programs at all levels. The legislation provides for a federal contribution of 50% of the costs of providing training for these persons.

Then there is a provision for financial assistance for the purpose of enabling persons to participate in either the vocational [*Continued on page 27*]

A STUDY OF REHABILITATION REPORTS 1960-61

With the co-operation of Provincial Rehabilitation Agencies it is now possible to obtain complete information regarding the vocational rehabilitation of many of the disabled persons in the various provincial vocational rehabilitation programs. Such reports are completed at the time when active rehabilitation services have terminated and after a suitable period of follow-up has confirmed that these individuals have reached definite "rehabilitation status".

The number of such persons reported as rehabilitated during the fiscal year 1960-61 totalled 1,614, according to reports from provincial rehabilitation co-ordinators. These reports reveal some interesting facts and facets of the rehabilitation program and we reproduce some of the figures here for your information.

TABLE 1—Breakdown by Age, Sex, Dependents, and Location

DISABILITY GROUPS	Amputations	NMS*	Hearing	Seeing	Neurological	Respiratory	Cardio-Vascular	Neuro-Psychiatric	Miscellaneous	Total
AGE GROUPS										
Under 20	5	55	32	7	14	28	2	20	5	168
20 to 30	28	222	33	50	54	123	17	76	13	616
31 to 40	22	131	11	33	25	51	12	31	15	331
41 to 50	24	81	3	20	34	33	10	17	9	231
51 to 60	15	50	5	17	19	8	4	6	5	129
Over 60	19	50	14	18	23	3	5	1	6	139
SEX										
Male	90	390	47	89	108	150	35	98	37	1044
Female	23	199	51	56	61	96	15	53	16	570
NUMBER OF DEPENDENTS										
	124	567	14	105	110	160	66	84	46	1276
LOCATION										
Urban	65	323	72	103	113	171	29	100	33	1009
Village	19	110	9	12	18	37	9	22	4	240
Rural	29	156	17	30	38	38	12	29	16	365

You will note that 69 per cent of these rehabilitated people are under 41 years of age, and have many years of productive life ahead of them.

*Neuro-Muscular, Skeletal.

About 55 per cent had only an elementary education, and 89 per cent had not reached Junior Matriculation level. Only three per cent had any previous vocational training.

TABLE 2—Educational Status at Acceptance

DISABILITY GROUPS	Amputations	NMS*	Hearing	Seeing	Neurological	Respiratory	Cardio-Vascular	Neuro-Psychiatric	Miscellaneous	Total
Nil	7	23	3	—	9	1	2	5	1	51
1 to 4 years	13	45	10	10	11	11	2	21	10	133
5 to 8 Years	53	264	66	61	58	99	20	60	19	700
9 to 12 Years	28	197	16	54	57	111	24	50	17	554
Junior Matriculation	8	30	2	11	23	15	1	6	4	100
Senior Matriculation	2	24	—	8	6	8	1	8	1	58
University	2	6	1	1	5	1	—	1	1	18

TABLE 3—Comparisons of Occupations Before and After Rehabilitation

PRINCIPAL PREVIOUS OCCUPATION										
DISABILITY GROUPS	Amputations	NMS*	Hearing	Seeing	Neurological	Respiratory	Cardio-vascular	Neuro-Psychiatric	Miscellaneous	Total
Professional and Managerial	6	17	—	6	6	9	—	2	3	49
Sales and Clerical	18	67	6	31	19	44	9	22	6	222
Service Occupations	18	100	21	28	34	37	10	23	8	279
Agriculture, Fishery, Forestry, etc.	10	61	5	5	16	19	4	8	6	134
Skilled Occupations	3	40	—	13	13	17	8	5	4	103
Semi-Skilled Occupations	12	54	2	8	10	20	3	8	6	123
Unskilled Occupations	34	105	23	19	24	52	8	30	12	307
No previous occupation	12	145	41	35	47	48	8	53	8	397

OCCUPATION AFTER REHABILITATION

DISABILITY GROUPS	Amputations	NMS*	Hearing	Seeing	Neurological	Respiratory	Cardio-Vascular	Neuro-Psychiatric	Miscellaneous	Total
Professional and Managerial	6	38	2	11	8	12	1	4	3	85
Sales and Clerical	18	140	9	38	40	103	12	38	12	410
Service Occupations	29	136	30	4	27	65	16	46	11	364
Agriculture, Fishery, Forestry, etc.	9	36	1	1	5	4	2	4	2	64
Skilled Occupations	7	53	3	7	9	21	5	3	6	114
Semi-Skilled Occupations	8	54	13	10	13	16	4	8	5	131
Unskilled Occupations	15	78	21	15	11	19	4	42	9	214

TABLE 4—Status After Rehabilitation

DISABILITY GROUPS	Amputations	NMS*	Hearing	Seeing	Neurological	Respiratory	Cardio-Vascular	Neuro-Psychiatric	Miscellaneous	Total
Regular Employment	82	483	76	75	96	226	40	132	44	1254
Self-Employment	10	36	2	2	6	13	4	6	1	80
Sheltered Employment	—	5	1	5	5	—	—	6	3	25
Home-Bound Employment	—	11	—	4	6	1	—	1	—	23
Self-Care	21	54	19	59	56	6	6	6	5	232

TABLE 5—Comparison of Financial Status Before and After Rehabilitation
STATUS AT ACCEPTANCE (SOURCE OF SUPPORT)

DISABILITY GROUPS	Amputations	NMS*	Hearing	Seeing	Neurological	Respiratory	Cardio-Vascular	Neuro-Psychiatric	Miscellaneous	Total
Dependent on Public Assistance	30	152	14	71	46	116	12	49	21	511
Dependent on Relatives	36	272	58	29	84	86	19	78	17	679
Earning under \$500 p.a.	2	6	1	1	—	—	—	1	—	11
Earning \$500 to \$1000 p.a.	16	62	13	21	14	26	6	5	8	171
Earning \$1001 to \$2000 p.a.	16	57	9	16	12	14	9	15	3	151
Earning Over \$2000 p.a.	13	40	3	7	13	4	4	3	4	91

*Neuro-Muscular, Skeletal.

ANNUAL EARNINGS AFTER REHABILITATION

DISABILITY GROUPS	Amputations	NMS*	Hearing	Seeing	Neurological	Respiratory	Cardio-vascular	Neuro-Psychiatric	Miscellaneous	Total
Under \$500	—	11	1	6	4	—	—	10	2	34
\$500 to \$1000	20	89	11	11	25	13	6	22	8	207
\$1001 to \$2000	22	151	41	31	33	63	12	60	10	423
Over \$2000	50	284	26	38	51	164	26	53	28	720

In comparing occupations before and after rehabilitation, note that there is a shift away from those occupations dependent mostly on physical strength towards the occupations where training and skill are more of a requisite. You will note too that many of the 397 who had never before been employed have become absorbed into productive employment.

Before rehabilitation, 73.7 per cent were dependent on public assistance or relatives for support, at an estimated annual cost of \$954,304. Now, 85 per cent are engaged in some form of remunerative work, with annual earnings estimated at \$2,730,502.

The World Commission on Vocational Rehabilitation

Canada is supplying the first Chairman for this new Commission which was established recently by the International Society for the Rehabilitation of the Disabled.

The importance of vocational goals in any program of rehabilitation was one of the principles recognized by the International Society for the Rehabilitation of the Disabled as it adopted this new name at its Eighth World Congress in 1960. To give proper emphasis to the vocational aspects of rehabilitation in its total program the Society at that time, established a World Commission on Vocational Rehabilitation.

The Commission will work for, and through, the International Society and with other organization to promote the employment of the disabled as a major objective in rehabilitation. To this end the World Commission on Vocational Rehabilitation will undertake to:

- (1) stimulate appropriate action in all parts of the world to meet the vocational needs of disabled individuals;

- (2) collect information on employment of the handicapped and disseminate it to the general public throughout the world as part of the International Society's current education and information program;
- (3) serve as a focal point for identifying needed research and to advance knowledge in, and application of, vocational preparation and employment of the handicapped;
- (4) stimulate the development of sheltered employment opportunities, to provide work training and employment for those who are not readily able to secure other work;
- (5) carry on such additional activities as are necessary to accomplish the objectives of the Commission.

As a specialized group within the total program of the International Society, the Commission will use the facilities of the International Society to collect, translate and distribute publications, films and other information material; co-operate with the International Labour Organization in promoting the implementation of Recommendation 99 adopted by the I.L.O. in 1955; organize and assist in organizing special seminars dealing with the problems of employment of the handicapped; encourage voluntary organizations of employers and workers to co-operate in providing opportunities for the employment of the handicapped; participate in World Congresses and Regional Conferences and make recommendations regarding their vocational content and co-operate with other expert commissions of the International Society and other organizations concerned with the medical, social and educational aspect of rehabilitation. The Commission will be composed of individuals primarily concerned with the vocational aspects of rehabilitation. At the present time 23 members, representative of 20 countries, have been appointed to the Commission. Additional members will be appointed as recommendations are received from member countries. Mr. Hall H. Popham, President of the International Society, recently announced the appointment of Mr. Ian Campbell, National Co-ordinator, Civilian Rehabilitation,

Department of Labour, Ottawa, Canada, to act as Chairman of this body.

The Commission has established headquarters in New York with Mr. John Nesbitt as Director.

A New Member of National Office Staff

Civilian Rehabilitation welcomed a new member of its staff in October, Miss Valerie A. Sims of Montreal.



Miss Sims is well qualified for her new post. A graduate of McGill University with a Master of Social Work degree, she has specialized in medical-social studies. She attended Sir George Williams College in Montreal and later studied at the London School of Economics.

Miss Sims has held positions in both Canada and Britain. Overseas, she was engaged in social work with the London County Council and in re-settlement work at the Queen Victoria Hospital, a plastic reconstruction centre in East Grinstead, Sussex.

Before going to Britain, Miss Sims was employed at the Allen Memorial Institute of Psychiatry, Montreal.

Prior to taking up her new position with Civilian Rehabilitation, she was the Senior Medical Social Worker at the Royal Victoria Hospital, Montreal, where she was engaged in resettlement in the community of disabled persons who had undergone treatment at the hospital.

THE DIVISION ON OLDER WORKERS

Following a directive from the Honourable Michael Starr, Minister of Labour, to intensify efforts on behalf of older workers, a division was established under the direction of the National Co-ordinator, Civilian Rehabilitation, with a small staff devoting full time to the social and economic problem of the older worker.

The Division on Older Workers commenced operations on a full time basis in 1959. Its functions include co-ordination of the activities of the Labour Department generally in the field, the stimulation and encouragement of educational efforts in co-operation with the Information Branch; encouragement of research in cooperation with the Economics and Research Branch and other agencies interested in problems of aging; liaison with welfare and voluntary agencies and with provincial government officials interested in the subject; liaison with agencies abroad; studying developments in the field in other countries; and the assembly and dissemination of informational material.

The following material can be obtained free by writing to the Division on Older Workers, Civilian Rehabilitation, Department of Labour, Ottawa:

Speaking Out About the Older Worker Problem: a series of radio broadcasts. Available in French and English.

Pertinent Facts About the Older Worker: a reference manual, prepared and assembled by the Information Branch, Department of Labour, Ottawa, June 1961.

Discrimination Against Older Workers: a reprint of an article from the International Labour Review, Vol. LXXXII, No. 4, April 1961, by the Division on Older Workers. Available in French and English. (Limited supply)

Attitudes and Older Workers: Address by the Minister of Labour to the Canadian Council of Foreman's Clubs, October 28, 1960.

Don't Judge A Man's Worth By His Date of Birth: An examination of the myth of the older worker—a series of articles prepared by the Information Branch, Department of Labour.

Here's Five Step Program That Could Work For You: by E. J. Hickey, reproduced from "The Financial Post", June 24, 1961.

The High Cost of Labour Turnover: From May 1960 issue of Labour and Employment Gazette, published by the New Zealand Department of Labour.

How Safe Are Your Older Workers: by V. A. Broadhurst, reproduced from "Industrial Welfare".

The Care Of The Geriatric Citizen: A study by the New Brunswick Association of Registered Nurses.

The Older Worker: By Dr. F. W. Hanley, reproduced from

the Canadian Personnel and Industrial Relations Journal by the Division on Older Workers, Department of Labour.

Too Old At 40: By Andrew Snaddon, 1959.

When An Older Woman Wants A Job: Reproduced from the January 1954 issue of the Ladies Home Journal.

Why Ex at XL?: a digest of two case studies of the relation between age and selected characteristics of sales personnel in two department stores by Douglas G. Dainton.

Victims of a Myth: A brief digest prepared by the Information Branch, Department of Labour.

Pension Plans and the Employment of Older Workers: 2 minutes of employment facts prepared by the Information Branch, Department of Labour.

The Employability of the Older Worker: A review of research findings by S. D. Clark, University of Toronto. (Limited supply)

Industry and Retirement: By Irene Kingston, B.A., Occupational Health Division, Department of National Health and Welfare, Ottawa. (Limited supply)

Early Retirement Takes Interesting Turns: Source, The Christian Science Monitor, Boston, Mass. August 1, 1960.

Problem of Work for Older People: Reproduced from the March 7, 1959 issue of the Manchester Guardian.

Productivity of Older Workers: by Leon Greenberg, March 1961 issue of "The Gerontologist".

MATERIAL PERTAINING TO PENSION PLANS

How Canada's First Proper Purchasing Power Pension Plan will Operate: James L. Clare, M.A., F.S.A.

Industrial Pension Plans—1959: School of Business Administration of the University of Western Ontario, R. E. Sproule and J. J. Wettlaufer.

Portable Pensions: By J. C. Maynard.

Practical Pension Plans: By Cyril J. Woods, F.I.A., F.S.A.

Study of Canadian Pension Plans: Summary of findings of a study of Canadian pension plans—1960

The Preservation of Pension Rights: Ontario Department of Economics 1960.

Vesting Provisions in Pension Plans: Walter W. Kolodrubetz, U.S. Department of Labor.

CANADA AT WORK—RADIO BROADCAST SERIES

Pension Plans and the Employment of Older Workers: Arthur H. Brown, N-704, February 23, 1958.

Housing for Older People: Humphrey Carver, Central Mortgage and Housing Corporation. N-869 April 23, 1961.

Age And Performance: Ian Campbell, National Co-ordinator, Civilian Rehabilitation, Department of Labour, Ottawa. N-834, August 21, 1960.

What Does Old Age Mean to You: Miss Hazeldine Bishop, Executive Assistant, Older Persons Section of the Montreal Council of Social Agencies. N-871, May 7, 1961.

Barriers Can Disappear: Ian Campbell, National Co-ordinator, Civilian Rehabilitation, Department of Labour, Ottawa. N-879, July 2, 1961.

Let's Eliminate Age Barriers in Hiring: H. L. Douse, Chief, Division on Older Workers, Civilian Rehabilitation, Department of Labour. N-880, July 9, 1961.

National Employment Service and the Older Worker: C. A. Murchison, Commissioner, Unemployment Insurance Commission, Ottawa. N-881, July 16, 1961.

The Older Woman and the Working World: Miss Marion V. Royce, Director of the Women's Bureau, Department of Labour. N-892, October 1, 1961.

Retirement Practices and Their Implications: A. Andras, Director of Legislation, Canadian Labour Congress, Ottawa. N-893, October 8, 1961.

Do you Support Your Pension Plan Or Does Your Pension Plan Work For You: James L. Clare, M. A., F.S.A., Actuarial Consultant and former Professor of Actuarial Mathematics at the University of Manitoba. N-894, October 15, 1961.

Occupational Medicine and the Older Worker: Dr. D. K. Grant, Director of Medical Services, Hydro-Electric Power Commission of Ontario. N-895, October 22, 1961.

Finding Jobs for Older Workers: A. F. MacArthur, Commissioner, Unemployment Insurance Commission, Ottawa. N-896, October 29, 1961.

The Older Worker and the Community: Hon. Michael Starr, Minister of Labour, Ottawa. N-897, November 5, 1961.

The following publications can be purchased by writing to the Queen's Printer, Ottawa:

Pension Plans and the Employment of Older Workers: A report prepared for the Interdepartmental Committee on Older Workers. Available in French and English. Price: 50 cents.

Age and Performance in Retail Trade: A report on two case studies of the relation between age and selected characteristics of sales personnel in two department stores. Available in French and English. Price: 25 cents.

The Aging Worker in the Canadian Economy: A statistical study of older people conducted by the Economics and Research Branch, Department of Labour, Ottawa. Available in French and English. Price: 25 cents.

A New Career After 30: A report of an enquiry into the experience of women who had taken professional social work training at 30 years of age or over, made by the Women's Bureau, Department of Labour. Available in French and English. Price: 25 cents.

(Summaries of the above four publications may be obtained free from the Division on Older Workers, Civilian Rehabilitation, Department of Labour, Ottawa.)

Employment Security for Older Workers

... increasingly recognized as a major problem in the field of aging

The White House Conference on Aging held in Washington in January of last year and the more recent Conference on the Employment and Retirement of Older Workers in Regina on June 1 and 2, 1961, indicate a growing concern for the aging and the place of the older worker in the economic and social life of the community. The many prob-

lems explored in Washington, employment security, income maintenance, health and medical care, rehabilitation, social services, housing, education and training and recreation, and the papers delivered in Regina, reflect similar areas of interest.

In the discussions on employment security and retirement the participants agreed that although there are significant individual variations in all age groups, extensive studies revealed no sound basis for the widespread belief that older workers as an age group are less productive, less reliable and more prone to accidents and absenteeism than younger workers. They were generally agreed on the desirability of vesting provisions in pension plans and expressed concern over the displacement of older workers in the labour market as technological innovations are introduced if there is not an adequate program of retaining provided.

It was agreed that the mature woman had a place in the employment market but since she is likely to have had an extended period out of the labour force while she raised her family there was a need for counselling, training, retraining and placement services to help her return to a position which would use to the full the knowledge and skills she has to contribute.

Canada was represented at the Washington Conference by Mrs. Jean Good, Toronto, and Miss Marie Hamel, Ottawa, Canadian Welfare Council; Miss Hope Holmstead, Toronto, Canadian Red Cross; Dr. Ian MacDonald, Canadian Medical Association; André Landry, Rev. Father Riendeau and Dr. F. Laurendeau, Province of Quebec; H. S. Farquhar, Province of Nova Scotia; Prof. James Clare, Province of Manitoba; Miss Lola Wilson, Province of Saskatchewan; Kenneth L. Hawkins and Donald Bellamy, Province of Ontario; Humphrey Carver, Central Mortgage and Housing Corporation; Dr. E. A. Watkinson and Mrs. Flora E. Hurst, Department of National Health and Welfare; Dr. John N. Crawford, Department of Veterans Affairs; Ian Campbell, National Co-ordinator, Civilian Rehabilitation, Department of Labour; and Pat Conroy, Labour Counsellor at the Canadian Embassy in Washington.

The 90 representatives of labour, government and Management from Saskatchewan, Alberta, Manitoba and Ontario who attended the Regina Conference heard addresses from such recognized authorities as W. G. Scott, Ph.D., Employment

[Continued on page 22]

Growth of Services for Mentally Retarded

Education and training of the mentally retarded is receiving increasing notice and attention all across the country. Among the many reports reaching us the following are indicative of developments that are taking place.

Committee on Mental Retardation Set Up In Saskatchewan

The Interdepartmental Co-ordinating Committee on Rehabilitation in Saskatchewan has established a Committee on Mental Retardation. Mr. W. G. Bates, Supervisor of Guidance and Special Education will act as Chairman. The Committee will study and report on the problems of mental retardation and the services available in Saskatchewan.

New Wing Opened at Winnifred Stewart School in Edmonton

On November 21, a new modern 18 classroom addition to the Winnifred Stewart School for Retarded Children was officially opened. This school provides education and craft training for 180 children from the Edmonton area.

Training Centre for Retarded Adults

In October, Windsor opened its retarded adults' training centre. The building, financed by the Windsor Association for Retarded Children and the Kinsmen Club of Windsor, was opened by Health Minister Dymond. It will have an initial capacity for 30 retarded adults.

25 Retarded Adults Celebrate Payday

December 21, was a red letter day for 25 retarded adults working at the Adult Training Centre of the Ottawa and District Association for Retarded Children. On that day pay checks were handed out for the first time at the Centre and was the first payday of their lives for many of the recipients. An adult training centre for the retarded has

existed in Ottawa since September 1959 but emphasis had been on craft work. With the move to new quarters last September a further step was taken when the centre became a sheltered workshop and training centre. Contract work has been undertaken and so well performed as to make this payday possible.

International Tuberculosis Conference

Last fall, for the first time since it was organized 40 years ago, the International Union Against Tuberculosis, with Dr. W. G. Wherrett of Ottawa as President, met in Canada. From September 10 to 14 more than 1500 delegates from some 67 countries gathered in Toronto. They came from all the continents. They represented all races, colours and creeds. Nations with centuries of history behind them and others with their history in the making were represented at the conference. Whatever their difference in culture or political ideologies they were here united in a common purpose. Pooling their knowledge and experience they were seeking ways of furthering the program for the eradication of tuberculosis as a major health problem in the world.

At the opening sessions six countries, the Republic of Mali, Malaya, Thailand, Sikkim, Formosa and the Ivory Coast, were admitted to membership. This brings membership in the union to 73 nations.

During the five days the delegates heard many scientific papers and reports on studies and research projects going on in many parts of the world, some international in scope. Besides scientific and medical matters the discussions included health education and the role of the voluntary organizations in promoting programmes of detection, prevention and rehabilitation included in a comprehensive program for tuberculosis control.

A simultaneous translation system, including the five languages of the conference, English, French, Russian, German and Spanish, enabled all to participate in the sessions.

Among the tours arranged in connection with the conference were visits to the Hospital for Sick Children, Toronto, the Gage Institute Chest Clinic and the Ontario Workmen's Compensation Board Hospital and Rehabilitation Centre at Downsview.

About 60 exhibits depicted advances in equipment and drugs used in diagnosis and treatment

[Continued from page 21]

Specialist of the Ontario Regional Office of the National Employment Service, Toronto; Miss M. V. Royce, Director, Women's Bureau, Department of Labour; Mr. A. Andras, Director of Legislation, Canadian Labour Congress and D. K. Grant, M.D., Director of Medical Services, the Hydro-Electric Power Commission of Ontario.

research projects being carried out and nursing procedures, health education and rehabilitation programs.

Crippled Civilians Pay Out \$4 Million in 26 Years

A real "rags to riches" story is to be found in the history of the Society for Crippled Civilians of Toronto, which raises wages for its 275 handicapped workers by repairing and remaking for resale discarded clothing and household articles donated by the public.

Little did the founders of the Society realize in 1935 that, by 1961, over four million dollars would be paid out in wages in the 26 years of its operation.

The first payrolls were small and difficult to raise in those mid-depression years, but hard work and honest efforts brought their reward. Real progress was made when the Society initiated this unique plan of accepting discards of clothing, furniture, household appliances, etc., donated by the public, and turning these into articles for resale in the Society's Training Centre. The money needed to pay wages was raised through the resale of these discarded articles to the public.

In the first few years, payrolls varied from \$90 to \$100 per week.

The growth of the Society during the last five years has been phenomenal. It took twenty years to raise and pay out the first two million dollars in wages; the second two million dollars has been raised during the last five years. Benefits to the handicapped, who shared in this four million dollar-wage payroll, have been varied and far-reaching. The opportunity to "Earn as you Learn", has made training possible for handicapped people who had no means of supporting themselves while in training. To others more severely handicapped and more difficult to place, the Society has provided an opportunity to earn wages and be self-supporting, rather than to be dependent upon charity.

We must not forget the homebound handicapped workers, which the Society keeps busy on simple tasks such as tag stringing, folding advertising material, carding goods, etc. Many of these people had never earned a wage before. Each week has meant new hope and an entirely new life to these unfortunate people.

Mention must also be made of Marina Creations, a division of the Society for Crippled Civilians, whose highly skilled homebound workers make

many beautiful luxury items which are available to the public through special sales.

The Society has brought a measure of happiness and independence to scores of people during its 26 years of service to the handicapped.

(Crippled Civilians Quarterly—Fall 1961).

C.A.R.S. Mobile Van to Service Rural Areas in Manitoba

The Manitoba Division of the Canadian Arthritis and Rheumatism Society are the proud owners of a mobile occupational therapy van, which will assist handicapped persons throughout Manitoba to regain some of their independence. The van will permit the Society's Occupational Therapist, Miss Shirley Munroe, to visit patients in their own home, to assess their physical handicaps, and help them in the activities of daily living.

The van is efficiently equipped with all types of wood-working tools, and these lock into place in an orderly fashion, to prevent their movement when the van is in motion. It would be difficult to find a tidier work bench. The van is also equipped with a propane heater for winter conditions, and there are electrical outlets for the power tools, which include a saw, drill and sander. Underneath the entire work bench there are drawers and shelves.

By the provision of simple gadgets which can be individually fitted as a result of the mobile workshop, the Occupational Therapist will be able to help the disabled housewife to look after her household duties.

Minor modifications to bathrooms, stairs and chairs, can often permit a person to function more efficiently. Special eating utensils can assist those with loss of grip or lack of arm movements, to feed themselves.

Many people with a stiff hip or leg can be instructed in putting on their own shoes and stockings, and dressing themselves.

Other aids can be given to persons with one leg or one arm, to enable them to carry out normal activities. Some men may resume work despite their handicaps, with slight modification in their work routine.

The Canadian Arthritis and Rheumatism Society will provide this service for any person in Manitoba, on their doctor's request.

A joint Federal-Provincial grant has made the service possible, and it should be of tremendous

value in restoring the usefulness of many people in Manitoba, who are unable to carry out normal day-to-day activities.

John Dolan Honoured for Work for Mentally Retarded Children

"With deep respect we pay tribute to W. J. Dolan, outstanding leader and friend. His interest and devotion on behalf of the mentally retarded has set a precedent of community responsibility, benevolence and brotherhood which serves as inspiration to all of us" so reads the illuminated address presented to Mr. Dolan along with a life membership in the Saskatoon Association for Retarded Children at a recent meeting in the John Dolan School. Mr. Dolan pioneered the work for retarded children in Saskatchewan. The school which he started with one teacher and six children has grown to its present enrolment of 70 pupils and a school named in his honour. The success of this project has influenced provision of similar facilities throughout Saskatchewan.

The Library of Congress Helps the Blind in Newfoundland

Three battery-powered record players for use with "talking books" will be available to blind people in Newfoundland who have no electricity.

The machines are on permanent loan to the local division of the Canadian Institute for the Blind, from the United States Library of Congress, division for the blind.

The talking books, which are actually recorded reading of books and magazines, can be borrowed from the C.N.I.B. library in Toronto.

The three new record players are sturdily constructed with twin sets of batteries. A wind-up spring revolves the turntable, with only the amplifier operated by batteries.

Available free of charge to any blind person, the record players and the records are carried free by the post office.

Ordinary electric record players have been available to blind people in Newfoundland for some time.

(St. John's Nfld Evening Telegram—May 1961)

Scouting for the Handicapped

The Boy Scouts of Canada have recently begun publication of "The Phoenix". The purpose of this little bulletin is to acquaint Scouters and others

with developments in Scouting for handicapped boys across Canada. Comments, suggestions, games, news items and program ideas will be welcomed by the Training Department, Boy Scouts of Canada, P.O. Box 3520, Station C. Ottawa 3, Ontario.

Ottawa Neighbourhood Services Opens a New Wing

The new wing of the Ottawa Neighbourhood Services is now completed and new machinery installed. This agency will now be able to increase its program of training and employment of handicapped workers. During the past summer, Neighbourhood Services provided employment for 91 handicapped persons.

The C.A. Pippy Awards for Handicapped Citizens of the Year

Mr. C. A. Pippy, President of the Newfoundland Rehabilitation Council, has generously offered two annual awards to outstanding handicapped citizens in Newfoundland. The President feels that an extra effort must be made to encourage the handicapped in their efforts towards social independence. The awards will be presented each year to the man and woman who, in the opinion of the Awards Committee of the Council, have demonstrated exceptional fortitude and perseverance in an effort to achieve independence.

Each award will consist of \$500.00 cash, donated by Mr. Pippy, plus a plaque which will be donated by the Newfoundland Rehabilitation Council. The Council has decided to recognize Mr. Pippy's philanthropy by naming the awards "The C. A. Pippy Awards for Handicapped Citizens of the year".

The Council feels that these awards will do much to encourage the handicapped who are striving to be independent, and will also be an incentive to others to make greater efforts to help themselves. It is realized that there are some individuals who may always have to depend solely on Government allowances, through no fault of their own, but many others can achieve some degree of independence.

The announcement of the awards came from the office of the Provincial Co-ordinator of Rehabilitation, St. John's, Newfoundland.

Canadian Conference on Physiotherapy

The Canadian Conference on Physiotherapy was convened in Toronto last May to consider the role of physiotherapists and the increasingly important part they play in meeting the health needs of an expanding nation. Jointly sponsored by the Association of Canadian Medical Colleges, The Canadian Association of Physical Medicine and Rehabilitation, and the Canadian Physiotherapy Association, the Conference brought together a representative group from university medical schools, medical specialties and physiotherapists to explore present day needs and facilities and to plan for the future with view to providing adequate service to meet the requirements of an increasing population.

The Conference considered the actual situation as to the ratio of physiotherapists to population in this country and compared it to other countries with a view to arriving at an estimate of what is a reasonable standard. They explored methods of training and the possibilities of extending or revising training programs in the light of revealed needs and existing facilities for training. Considerable attention was given to possibilities of expansion of training facilities as well as recruitment and the feasibility of attracting more male students into this field.

After a very thorough airing of ideas and possibilities a continuing committee was established to draft a report of the findings of the Conference and collect further data relevant to the future requirements of physiotherapy in terms of personnel, training, etc., and prepare recommendations designed to promote a sufficient supply of physiotherapists to meet Canada's future needs.

Administrative arrangements and secretarial services were provided by the Canadian Arthritis and Rheumatism Society and the Canadian Hospital Association.

School of Rehabilitation Medicine at University of British Columbia

The board of governors and the senate have approved the establishment of a school of rehabilitation medicine for the training of physiotherapists at the University of British Columbia, President N. A. M. MacKenzie has announced.

The school, which opened last September, has an enrolment of 15 students.

Students will be admitted to the school on completion of the first year of arts and science at UBC or its equivalent, or senior matriculation.

For admission to the school students will be required to have completed courses in English, chemistry, mathematics, zoology or biology in the case of senior matriculation, and one other elective.

The course leading to a certificate in physical medicine therapy will consist of three years of study. The first two academic years will be taught on the UBC campus followed by a third rotating supervised interne year.

After receipt of the certificate and two or more years of practice, therapists in good standing may return for a third academic year leading to a bachelor's degree.

Dr. Brock Fahrni, who has been named director of the school, said the training of therapists was "an urgent community health need". He said care in the field of chronic illness was suffering in B.C. because of a lack of trained therapists.

Dr. Fahrni said a number of organizations have signified their willingness to share in the cost of converting an existing building at UBC to house the school.

They are the Canadian Arthritis and Rheumatism Society, which has already announced a \$5000 grant, the Poliomyelitis and Rehabilitation Foundation of B.C., the G. F. Strong Rehabilitation Centre and the Vancouver Foundation.

Money for salaries and equipment, said Dr. Fahrni, would be received from the federal government in the form of rehabilitation health grants. At least two full-time persons will be appointed to the staff for the new school, he added.

The Fitness and Amateur Sport Act

On September 25, 1961, the House of Commons passed the Fitness and Amateur Sport Act, to "encourage, promote and develop fitness and amateur sport in Canada".

The Act is under the jurisdiction of the Minister of National Health and Welfare, who is empowered to carry on certain specific activities to further the aims of the Act.

For instance, the Act provides for assistance in the promotion and development of Canadian participation in national and international amateur sport.

It provides for the training of coaches and other personnel needed for the purposes of the Act, and provides for bursaries and fellowships to assist in such training.

The Department of National Health and Welfare can assist in research or surveys in the field of fitness and amateur sport, and can arrange for national and regional conferences. It can prepare and distribute information on fitness and amateur sport, and can recognize achievements in these areas by certificates, citations or awards of merit.

The Department of National Health and Welfare will be the co-ordinating agency for all federal activities related to the encouragement and development of amateur sport and fitness, and may assist, co-operate with and enlist the aid of any group interested in furthering the objects of the new legislation.

New Books

A Niche of Usefulness

Prepared by The Women's Bureau, Department of Labour, Canada—The Queen's Printer, Price 25c.

This publication shows how handicapped women may learn to help themselves with the aid of vocational rehabilitation services in Canada. The pamphlet sketches the history of rehabilitation services in Canada, tells how the services are organized and how individual women may make use of them.

Provincial programs of rehabilitation and the work of voluntary organizations in the field are described. Federal Government programs for disabled veterans and Indian and Eskimo Canadians are also explained, and one section deals with employment activities on behalf of the handicapped carried on by the National Employment Service and a number of voluntary agencies.

The final chapter of the book outlines careers available to women in rehabilitation and describes the role of the woman volunteer in various phases of work in this field.

A series of appendices provide useful listings of rehabilitation agencies, organizations and services in Canada and a brief statement of international action on behalf of the disabled.

The Parent of the Cerebral Palsied and the Community

The report of a study conducted by the Cerebral Palsy Section of the Canadian Council for Crippled Children and Adults into the relationship of parents and parent councils to cerebral palsy clinics, treatment centres and other community services. Price 50c.

Nurses Can Give and Teach Rehabilitation

By M. J. Allgire and R. R. Denney. Published by Springer Publishing Co., Inc., New York. Price \$1.25.

Housing for the Disabled

Dwellings for invalids who move about in wheelchairs and for those who move about with the aid of crutches or sticks. Published originally in Dutch and English editions, it is available from the International Society for the Rehabilitation of the Disabled through the Canadian Council for Crippled Children and Adults, Suite 115, 31 Alexander St., Toronto, Ontario.

New Films

Rehabilitation in Paraplegia

Emphasizes the over-all management of paraplegic patients from the time of admission to the rehabilitation centre. Considerable space is set aside for demonstrating the activities of daily living, physiotherapeutic techniques and urological management. In colour, the film runs for thirty-one minutes. It is a sound film. For further information contact;

Paraplegic Association,
Lyndhurst Lodge Hospital,
153 Lyndhurst Avenue,
Toronto 4, Ontario.

The Prevention of Disability in Rheumatoid Arthritis

was given its première on May 3. Prints are now in all Division Offices of the Canadian Arthritis and Rheumatism Society.

[Continued from page 14] instructors in the special course organized in Rabat for Moroccan students in physiotherapy.

The conclusion of all this should probably mention the results of the completed Red Cross Program, as of June 30, 1961. Of the 10,466 original cases of paralysis, some 9,600 patients have been discharged from further treatment at the end of June. The approximately 340 paralytic victims expected to require regular treatment after 30th June, and about the same number still subject to periodic medical control, will receive this under the Moroccan Ministry of Health Program operated by Moroccan staff, especially trained in physiotherapy work during the past year for this purpose, assisted by a small group of international personnel working under Government contract.

[Continued from page 15]

In attempting to fulfil its role in rehabilitation, NES does so, not for compassionate reasons, although compassion is a quality usually abundant in special placement officers. On the contrary, our obligation to Canada's disabled stems solely from our responsibility as the public employment service which, by ILO Convention 88, is charged with ensuring "the best possible organization of the labour market as an integral part of the national program for the achievement and maintenance of full employment and the development of productive resources". If we are to discharge this responsibility, we must do everything possible to develop the productive potential of the disabled and, by placing them in suitable employment, enable them to make their maximum contribution to the economy of the nation.

[Continued from page 16] teacher training program or the programs providing training in the principles of science and technology and the application thereof as required in the training of technicians and technologists.

The new Agreement carries forward and continues provision for a federal contribution of 75% of the costs of programs for training of unemployed persons as well as the programs which provide a sharing of the costs, on a 50-50, basis of the training for disabled persons.

Provision has been made in the Agreement for more actual training programs to be developed in co-operation with industry. These may take the

form of standard apprenticeship training plans, enlargement of present programs for training instructors in industry, introduction of new training programs by industry in co-operation with the provincial and federal governments, and programs for upgrading skills of employees to meet the continuing manpower need and changing occupational requirements. It is hoped that industry will accept a larger share of the responsibility for, and develop a greater interest in the establishment of suitable training programs to meet its needs.

Activities under the Technical and Vocational Training Agreement are based on federal-provincial co-operation. As in all matters affecting education, the initiative rests with the provinces. For this reason, the Department of Labour in co-operation with the provinces, made a comprehensive study of training needs in the provinces, and of provincial plans for the future, before the Agreement was drawn up, so that federal assistance under the Agreement would be as practical and useful as possible.

The following are the addresses of the rehabilitation offices in the various provinces:

Provincial Co-ordinator of Rehabilitation,
Department of Health,
Post Office Box E5250,
ST. JOHN'S, Newfoundland.

Deputy Minister,
Department of Welfare and Labour,
CHARLOTTETOWN, Prince Edward Island.

Provincial Rehabilitation Co-ordinator,
Department of Public Health,
Post Office Box 488,
HALIFAX, Nova Scotia.

Director and Co-ordinator of Rehabilitation,
Department of Health,
FREDERICTON, New Brunswick.

Physically Handicapped Division,
Department of Youth,
9175 St. Hubert Street,
MONTREAL 11, Quebec.

Provincial Co-ordinator of Vocational Rehabilitation,
Department of Public Welfare,
85 Eglinton Avenue East,
TORONTO 21, Ontario.

Provincial Co-ordinator of Rehabilitation Services,
Department of Health,
Room 615, Norquay Building,
WINNIPEG 1, Manitoba.

Provincial Co-ordinator of Rehabilitation,
Health and Welfare Building,
REGINA, Saskatchewan.

Department of Public Welfare,
109th Street and 98th Avenue,
EDMONTON, Alberta.

Attention: Mr. John G. Fricke.

Rehabilitation Co-ordinator,
Department of Health Service and Hospital Insurance,
828 West 10th Avenue,
VANCOUVER 9, British Columbia.



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1962



Rehabilitation **IN CANADA**



Published in the interests of Canada's Disabled by ...

CIVILIAN REHABILITATION

Department of Labour Canada

CONTENTS

Page

- 4 The Sheltered Workshop in the Rehabilitation Process
- 8 The Sheltered Workshop of the Jewish Vocational Service
- 14 Marina Creations
- 20 Sheltered Employment in Canada
- 23 Improving the Program and Image of the Sheltered Workshop
- 25 First Meeting of the National Advisory Council
- 29 People and Events

ROGER DUHAMEL, F.R.S.C.
QUEEN'S PRINTER AND CONTROLLER OF STATIONERY
OTTAWA, 1962

To our Readers . . .

WE HAVE BEEN greatly encouraged by the favourable comments on our first issue of this Bulletin. It is our hope that it may become the voice of rehabilitation in Canada and that, through its pages, workers with experience will share with others the knowledge they have gained. If you have carried out a successful experiment or piece of research, or devised a new method in your particular field, please write us about it. We plan to publish articles from time to time by authorities in the various fields of work which make up the total rehabilitation program. In order to do this, we need the co-operation of all interested people.

This issue is focussed on sheltered employment. In view of the attention that is being given to this subject in Canada today, and with the impending Canadian conference on this topic in mind, we have tried to bring you something of the current thinking about the place of sheltered workshops in rehabilitation programs. A variety of sheltered workshop programs are being conducted across Canada. Of course, only a few can be reported on in one issue, but we have tried to include those which typify different kinds of operations and illustrate some of the major workshop services such as vocational assessment, work adjustment, job training and terminal employment.

With increasing concern for the vocational rehabilitation of disabled persons, many communities and organizations are turning their attention to the provision of sheltered employment facilities. There are a number of questions to be considered in instituting such programs: the needs of the community; the role of the workshop; how it fits into an over-all vocational rehabilitation program and how it can be related to other rehabilitation services in the locality. These are all questions which must receive careful consideration if the best results are to be obtained.

We hope that this issue of the Bulletin will provide some guidance to community planning in this area of rehabilitation service.

THE SHELTERED WORKSHOP IN THE REHABILITATION PROCESS

By

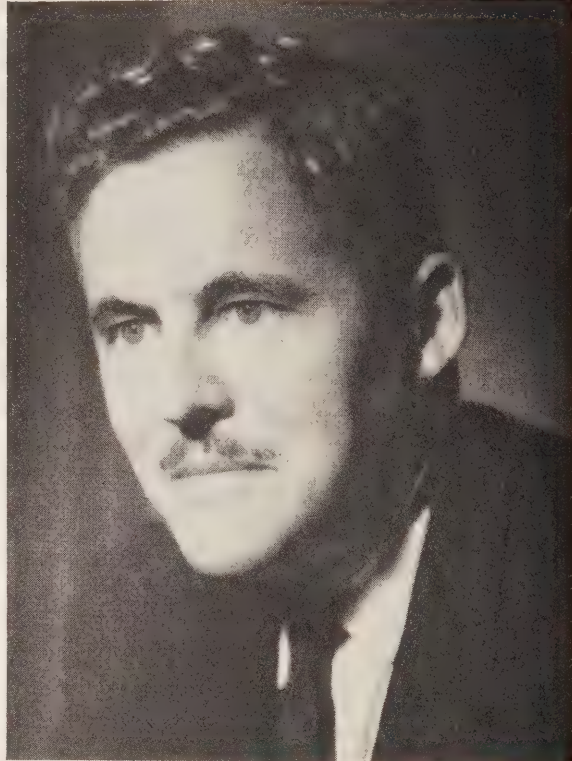
Dr. K. S. Armstrong,
Executive Director
Canadian Council for
Crippled Children and Adults

(The following address, delivered at the Workshop on Sheltered Employment in St. Sauveur des Monts, Quebec, in April, 1961 is reprinted here with the author's permission.)

THE results of the survey conducted by the National Co-ordinator's office produced some interesting facts. Excluding the vocational workshops of the Canadian National Institute for the Blind, this study showed across Canada twenty-four sheltered workshops, employing an average of twelve hundred persons a month. Most of these workshops operate on a deficit which is made up largely through voluntary funds. Fifty percent of those employed can be considered terminal cases. The earnings of the employees range from 33 cents per hour to \$1.20.

Perhaps the most significant facts are that over one-third of those employed find their own way to the workshop, and over one-half of those who eventually find employment on the open labour market do so through their own efforts. In the great majority of workshop programs there is only a casual relationship between other rehabilitation services where assessment, evaluation, medical, psychological, social or vocational information concerning the client could be obtained.

From this survey, it is obvious that twelve hundred persons a month must be but a fraction of the number of Canadians who could benefit from the experience which the workshop has to offer. There is a growing feeling among many that in providing adequate rehabilitation services more workshop programs are necessary. There is particular pressure from special groups—the aged, mentally retarded, emotionally disturbed and cerebral palsied. It is apparent from this survey that as the numbers of workshop projects in-



Dr. Keith Armstrong, M.A., Ph.D., has been National Executive Director of the Canadian Council for Crippled Children and Adults since 1953. In this position he has become well known to rehabilitation workers both in Canada and abroad. Dr. Armstrong was born in Japan. He graduated from Toronto University with an M.A. in 1933 and then worked with Canadian Indians in Northern Manitoba for three years and for the Student Christian Movement at the University of Manitoba for a couple of years before returning to the University of Toronto to attend the School of Social Work. Having obtained a diploma in this field he became Superintendent of the Children's Aid Society in Temiskaming. In 1943 he received an appointment as Director of Child Welfare in the Department of Social Welfare in Saskatchewan. In 1948 he became Director of Physical Restoration for the Department of Health in the same province and became Executive Director of the Provincial Council for Crippled Children and Adults. He added a Ph.D. to his academic qualifications in 1954 through study at New York University.

crease, many problems will present themselves for which none of us have ready answers.

Classification of Workshops

Workshops can be classified in a number of ways—by the type of work performed, such as the reclamation of used goods, sub-contract work, industrial production or manufacture of crafts. They can also be grouped by the clientele served—

the aged, mentally retarded, physically disabled, emotionally disturbed, or specific disease groups. They can be classified by their aims and objects—places of terminal employment, work testing programs and training centres.

Which of these types of workshops are practical in smaller communities where the population does not lend itself to highly specialized units? What do we see the relationship to be between sheltered employment and other services to the handicapped? Apparently in Canada very few of the sheltered workshops feel that they have any direct relationship to the other facilities. How should these programs be financed? What qualifications for staff should be required? As more professionally trained people become interested in this area of activity, the cost of administration rises accordingly. Is professional leadership required in what is commonly described as basically a sound business operation?

Question of Definition

The answer to these and many other questions depends on how we define the term 'sheltered workshop'. On this question of definition we can find no general agreement. I have seen the term 'sheltered workshop' defined in such a way that it is almost synonymous with the entire rehabilitation process. I have seen it defined as a place where those who have been rejected by all other community services find refuge. I have seen definitions which come anywhere in between these extremes.

Personally, I am not too concerned with spelling out a definition at this point. I would like to comment on what I consider to be three basic questions, the answers to which can be the basis for solving many of our doubts and questions regarding sheltered workshop programs.

My first question is—What unique contribution does a sheltered workshop make to the total rehabilitation process? A rehabilitation centre, we know, has, as its primary aim, the physical restoration of the individual, taking into consideration the emotional and psychological problems which hinder or prevent physical improvement. A vocational rehabilitation program is educationally oriented. Its primary objective is to prepare the individual for competitive employment through the development of his particular skills.

The sheltered workshop basically provides a work experience without the stress and tension of competitive employment. It can be used as part of a therapeutic program for training purposes, but the one feature it offers, which is unique, is a realistic work situation in a controlled environment. When we think in terms of sheltered workshops as being places where we can develop programs for work diagnosis, or work conditioning or job testing, we are using the sheltered workshop facilities to attain specific goals which are not in themselves a basic function of the agency.

This is an important distinction to make, because, if we accept it, then it answers many of our doubts regarding the justification of sheltered workshops becoming places of terminal employment.

The importance of sheltered employment is directly related to the significance which our society places on the concept of labour. The UNIVERSAL DECLARATION OF HUMAN RIGHTS, which, through the United Nations, is becoming a part of our heritage, states:—"Everyone has a right to work, to free choice of employment, to just and favourable conditions of work, and protection against unemployment." There is no exception made in the case of the severely disabled.

This is an important clause in this declaration, because man's labour in terms of the wages it produces has become equated with his ability to participate in and enjoy the way of life which his community has established for its members. The problem of the disabled lies in the fact that whatever other contribution he can make to the life of his community, the wage he is paid for the labour he is able to perform is not sufficient to enable him to attain the way of life which is characteristic of the community of which he is a member. The corollary to this is the fact that whatever our society grants to the disabled to provide him with security in the form of disability pensions or social assistance—that money has an entirely different psychological significance than wages paid for work accomplished.

Requirements of Service

My second question—What group in the disabled population should the sheltered workshop serve? On the face of it, the answer is very simple

and obvious. Only those who, after every opportunity has been afforded them, cannot earn their wages through labouring in a competitive situation. Unfortunately, the question is more readily answered than put into practice.

Actually the problem of work for the disabled is not different from that faced by any young person who is deciding what his career should be. He must take into consideration a great many factors, many of which are beyond his control, and to which he must adapt himself. The two most important of these are the degree of his physical fitness and his mental ability to cope with his ambition. In addition, there are many others, the economic conditions of his country, his social status, the opportunities or lack of opportunity which his geographic location imposes, the demands for certain skills in industry, the demand for labour, and the way of life to which he aspires.

Those who are physically fit and mentally alert have a wide selection of opportunities from which to choose. Those who are physically unfit and lack mental ability have little or no choice. Most of us fall somewhere in between these extremes.

Goal of Rehabilitation

The goal of the rehabilitation process is to upgrade the physically and mentally disabled on this opportunity scale. If we are to accomplish this for the severely disabled, then it is essential that the sheltered workshop have access to the best evaluation, treatment, and training facilities; and that its own operation be used in this upgrading process.

My third question—How can the sheltered workshop be integrated into the total rehabilitation process? Many sheltered workshop programs have quite rightly resisted pressure put on them to develop rehabilitation facilities within their organizations. The sheltered workshop is a non-profit organization operated in the interests of its employees who cannot function in competitive employment, but in all other respects it is a business enterprise and must be run and operated on sound business practices. If the administrative costs are expected to include the professional services necessary to provide for adequate assessment, evaluation, and training, then it becomes a rehabilitation facility in which work as such is incidental, and it cannot then be classed as a sheltered workshop. An attempt to answer my

question raises the far more fundamental question as to the relationship of any one service to another in the rehabilitation field.

Need for Integration of Rehabilitation Services

Last Fall I had a very interesting experience. A visitor from Denmark had spent a week visiting rehabilitation facilities in Montreal and Toronto. He had exchanged ideas with many of us in the two cities and had been much impressed with our approach to rehabilitation. There is a certain affinity between the Danish people and Canadians, so that the visit had been pleasant all around. On the Saturday afternoon we went up Lake Scugog in my cruiser. About ten miles up the lake we stopped at a place where I had not previously stopped, and went ashore to explore the countryside. We were walking along a rough side road, past some cottages, when we heard a radio. It was a broadcast of the football game. We stopped to catch the score. As we were listening a man called to us to come on his verandah to hear the game. He was a man of about sixty-five, confined to a wheel chair as the result of some progressive condition which had struck him late in life. He and his wife lived in this isolated summer cabin until the weather became impossible, then they would move in with one of their children. As we seemed to be friendly strangers he started to tell us the story of his life.

Long years of steady work, in the city of Toronto, during that period a home-owner and a happy family situation, marked him as an average citizen. Then came this disease, decreasing ability to hold his job, and early retirement. When the children became independent he sold his home and temporarily moved away from the city. When his condition worsened, and it became necessary for him to settle in one place and to seek assistance, he found that he had lost residence rights in the city of Toronto. His savings were disappearing and they were now facing a rather desperate situation. Neither he nor his wife were prepared to burden their children and their spouses with the responsibility of caring for them. They very emphatically stated that their children had a right to make their own lives, and the presence of grandparents in the home was not always conducive in these days to happy living.

At no time had he ever been referred to a rehabilitation agency. But had he been referred, to which agency in Toronto should the referral have been made? What would have been offered him beyond possible assistance in the purchase of a wheel chair? When we returned to the boat I remarked to this Danish friend of mine—"Now you have seen rehabilitation in practice, as well as in theory."

Central Problem

This to me is the central problem in rehabilitation. There are too many people today in our cities and in our rural areas who are not being given access to the services they need because a description of their particular problem does not fit into the intake policies of any agency. We have learned what teamwork means in a rehabilitation centre, but we have not learned how to integrate our various rehabilitation services to meet the diverse needs of the total disabled population in the community.

Sheltered workshops should not have to set up their own assessment units, or evaluation schemes, or vocational testing programs. These services should automatically be available to them in a well integrated community program. On the other hand, the facilities of the workshop should be available to other services where work conditioning, work testing, or a practical work situation, is indicated to meet the need of a disabled person.

We would be wise to define a sheltered workshop by what its primary purpose is, rather than trying to define it as a work-oriented rehabilitation facility which, in fact, is expected to provide complete rehabilitation facilities to its clients. It is essentially a place where any manufacture or handiwork is carried on, and which is operated for the primary purpose of providing remunerative employment to severely disabled individuals who cannot be readily absorbed in the competitive labour market.

Need for Central Agency

The missing link in our rehabilitation services, I believe, is a central rehabilitation agency whose main function would be the integration of all the services in the community which can meet the individual needs of any disabled person. This agency could be established as a provincial or a local agency. It would be controlled through mem-

bership, and financial support, by the rehabilitation facilities in the community. It could act as a registry for disabled persons. It would undoubtedly be a source of factual information for community planning and research, but it would not in itself undertake research, nor would it have any control over any specific rehabilitation service. It would consist of a small selected staff whose major responsibility would be the integration of the various community resources to meet the particular needs of each disabled person.

In the case of the man whom my Danish friend and I so casually met, it would be hoped that the family doctor would at least know of this service. If he was not familiar with the various facilities in the community or their policies, he at least might be expected to know of this agency, and, through it, be put in contact with the rehabilitation centre where an adequate evaluation of the man's condition could be secured, and appropriate treatment provided. Through this agency the problem of his residence could be resolved. In checking this particular situation, I am reasonably sure there had been a misunderstanding, and in fact he had rights as a citizen of Toronto, which he thought had been surrendered.

It is important that a situation such as this be clarified. If a wheel chair were necessary, a service club or some other community group would be contacted. If sheltered employment were indicated, the rehabilitation centre could logically expect this agency to follow through. The necessary background information would be forthcoming from those services which had contact with this man, without the necessity of duplicating time and effort.

Such an agency, although primarily responsible to the needs of the disabled individual, would become a resource for all of us. None of us can be expected to meet the demands which are made on us by our job, and at the same time to know intimately the policies of all the services in the community which we at one time or another might wish to use. Such an agency would in no way interfere with any individual or service, because reporting to or the utilization of the services of this central agency would in no way be mandatory.

An agency of this kind becomes particularly important when we examine the problems of

[Continued on Page 28]

THE SHELTERED WORKSHOP OF THE JEWISH VOCATIONAL SERVICE

By

Dr. Alfred Feintuch,
Executive Director

WELFARE organizations have long been concerned about the many people who, because of advanced age, physical, mental or emotional disabilities, are unable to support and maintain themselves. Even during periods when labour market conditions are favourable, employment counsellors are confronted with many applicants who are unable to find and keep employment because they do not meet employer specifications or do not possess appropriate attitudes and work habits. The majority of such people, whose employability in industry is frequently impaired by advanced age, physical, mental or emotional disabilities, are often anxious to work, both in order to contribute to their own support and that of their families and to feel that they are worthwhile contributing members of society.

History and Philosophy

After much preliminary discussion and planning by a committee representing the Federation of Jewish Community Service of Montreal, the Jewish Vocational Service, and the Baron de Hirsch Institute, it was decided that a sheltered workshop was essential to meet this need. Such a sheltered workshop was opened on an experimental basis in November, 1950. It was agreed that while the workshop would be financed by Federation, its administration would be the responsibility of the Jewish Vocational Service. That this program succeeded in fulfilling the need for which it had been established is evident by the fact that it has been expanded twice since its relatively meagre beginning some eleven years ago.

Before the workshop could be established, it was necessary to agree upon its objectives. It was decided that the workshop would be geared to giving employment to persons who, because of advanced age, physical, mental, or emotional dis-



Dr. Alfred Feintuch received his education at Brooklyn College and at New York University where he majored in vocational guidance and psychology. He served as Guidance Counsellor with the New York Board of Education and the New York State Employment Service as well as in other government service.

Dr. Feintuch came to Canada to assist in the development of the newly-established sheltered workshop of the Jewish Vocational Service in Montreal. As executive director his has been the guiding hand that has piloted this program through the early experimental stage to its present firmly-established place as an integral and important part of this valued community service.

Dr. Feintuch has made a number of useful contributions to literature on work adjustment and sheltered employment programs.

He is a member of the National Vocational Guidance Association, the American Psychological Association, the Psychological Association of the Province of Quebec and the National Rehabilitation Association.

abilities, were unable to find or keep employment in regular industry but who could become partially, if not entirely, self-supporting under sheltered workshop conditions. While it was expected that some of the clients in the workshop would graduate to regular industry as a result of their

workshop experience, this was not considered basic to the program.

From its inception, the sheltered workshop has been operating according to the following principles:

1. Clients were to be paid on a piece-work basis and would receive all the money they earned.
2. The workshop would not be used to give employment, even on a temporary basis, to persons who, while difficult to place, were still considered placeable in the current labour market. The fact that the J.V.S. was having difficulty in placing these people would not be enough by itself to make them eligible for sheltered workshop employment.
3. The workshop would limit itself to doing contract work for manufacturers and jobbers and would not attempt to manufacture for sale. Contract work can be limited to simple operations, requiring simple equipment, and does not involve the purchasing of raw materials, the maintenance of inventories, and the need for a sales force and sales outlets.
4. Manufacturers and jobbers supplying work to the workshop must pay the workshop at least the same rates as they regularly pay for the same operation in their plants. Otherwise, the agency would be subject to the charge that it is setting sub-standard wage scales, or is helping one manufacturer

undersell his competitors by providing him with cheap labour.

Although the sheltered workshop sought to rehabilitate its clients to regular industry whenever possible, it was understood that the majority of persons accepted would be so handicapped that they would likely never become employable in industry. So that such clients could also be served, no limitation on the length of their stay in the workshop was established. The prime requirement for continuing in this shop, which we have since named our Indefinite Term Workshop, has been that clients give evidence of their continuing ability to benefit sufficiently from the service.

Sheltered Workshop Medical Program

In November, 1959, the sheltered workshop was awarded a Federal-Provincial grant in order that certain medical services might be provided within the facilities of the workshop. As a result of this grant, it was possible to secure the services, on a part-time basis, of medical and psychiatric consultants. In this way, we were able to accept into the workshop individuals previously rejected because of the severity of their handicaps. Under this aspect of the program, in addition to the vocational and psychological evaluation of clients, it has been possible to evaluate each client's physical and mental condition at the time of consideration for his acceptance into the workshop, during his workshop employment, and at the time of consideration for regular employment. This addition to our services has proven most valuable in many respects, not the least of which has been the opportunity for early discovery, and frequent prevention, of breakdown of our psychiatrically handicapped clients.

Services to clients have been improved by the holding of regular joint conferences of the combined vocational and medical staffs. With the assistance of the medical staff, our counsellors are better able to adapt their counselling techniques and to plan the work assigned to clients so as to enhance and speed their rehabilitation. Even for the so-called "terminal" group of clients, who are not expected to enter industry, on-the-spot clinics and psychiatric sessions have served to reduce unnecessary absenteeism and to promote increased productivity and more regular attendance.

The Jewish Vocational Service

The Jewish Vocational Service helps thousands of people from teenage to golden age, Canadian born or newcomer, to choose the right career or to find employment through its vocational counselling and job placement departments. In sheltered workshops the disabled are helped to return to productive life through assessment, work adjustment and training programs.

In Montreal, Dr. Feintuch directs the program of the Sheltered Workshop which recently moved to new and larger quarters. The official opening of the centre, located at 1190 Ducharme Ave., Outremont, was held on May 16, 1962.

In Toronto the Jewish Vocational Service conducts a workshop at 152 Beverley Street under the direction of Milton Friedman.

Our part-time medical staff, consisting of three specialists in their respective fields, have been assigned the following responsibilities:

1. Internist
 - (a) Completes a medical evaluation of each client being considered for the workshop.
 - (b) Conducts periodic check-ups of all clients in the workshop and ascertains that recommended medical treatment is being followed.
 - (c) Evaluates the feasibility, from a medical point of view, of a job in industry which is being considered for a particular workshop client.
 - (d) Maintains continuing medical records of all workshop clients.

2. Psychiatrist

For clients with known, or suspected, psychiatric involvement, our psychiatrist performs the same functions as outlined above but from the point of view of his own specialty. His reports are incorporated with-in clients' medical records. In addition, he advises our counsellors as to the psychological approach to be used with psychiatrically ill clients.

3. Physiatrist

In a consultative capacity, he is used to evaluate those clients whose needs fall with-in the area of physical medicine and to make recommendations for necessary treatment.

To augment the medical program, the Community Psychiatry Sub-section of the Department of Psychiatry of the Jewish General Hospital has provided us with the part-time services of a resident in psychiatry. He has conducted an experimental program of group therapy for a selected number of workshop clients. Although the number of sessions held thus far has been small, this approach has appeared so helpful to our clients that we intend continuing group therapy sessions this fall. These are held on the workshop's premises, during regular working hours.

A vital contribution of our medical staff has been the close liaison that they have maintained with existing hospital facilities in Montreal, particularly the Jewish General Hospital. Thus, the receipt of medical histories of our clients and the arrangements for necessary out-patient treatment

required by them during their stay in the workshop have been greatly facilitated.

Clients Served and Results

The nature of the clients served, and their disabilities, varies continually. However, one can get some picture of the heterogeneous nature of our client caseload from the following summary of the group served between November 1959, when our medical program was instituted, and April of this year.

SEX OF CLIENTS		
Male	Female	Total
46	20	66
AGE OF CLIENTS		
Age		Number
15 - 40 years		29
41 - 64		23
65 - 76		14
TOTAL		66

HANDICAP OF CLIENTS	
Type of handicap (clients may have more than one disability)	Number
Psychiatric and severe emotional problems	36
Cardio-vascular disease	16
Arthritis	8
Mental retardation	6
Epilepsy	4
Cerebral arteriosclerosis	3
Hemiplegia	3

In addition to the expansion of services afforded by the receipt of the Federal-Provincial grant for medical services, the Federation of Jewish Community Services of Montreal has authorized larger quarters and additions to our professional staff on two occasions, in 1958 and again recently in 1962. As a result, it was possible to effect dramatic changes in the number of man-hours worked, total earnings, and average hourly wages of our clients, as follows:

Year	Total Hours Worked	Total Earnings	Average Hourly Wage
1957	10,296	\$ 3,016	.29
1958	22,330	7,474	.33
1959	26,676	13,061	.49
1960	33,994	13,716	.40
1961	35,514	15,973	.45

Over the years, we have found that our workshop efforts have brought the following results:

1. Many clients, who were unable previously to find or keep employment, were aided by

their experience in the workshop to secure employment either on their own or through our agency. For some, employment in the sheltered workshop helped them face and accept the reality of their own limitations for modern industry which they apparently were unable to do before, despite intensive counselling by both vocational counsellor and case worker. With others, the sheltered workshop experience seemed to bolster their self-confidence and helped them acquire good work habits and attitudes, enabling them to find and keep a place for themselves in industry.

2. A substantial number of clients have made a reasonably good adjustment to the workshop on a terminal basis. Many of them have become fully self-supporting in the workshop. While the productivity of some of the others has been low, it was felt that, with their positive attitudes toward the workshop, their potentialities were such that with continued experience their earnings would undoubtedly improve sufficiently. To these people, the sheltered workshop has proved of great value in improving their morale and self-respect by helping them become productive and partially self-supporting once again. In addition, they enjoy tremendously being part of a group and working with other people of their own age or similarly handicapped.
3. On the other hand, a number of the clients referred to the workshop were unable or unwilling to make even a minimal adjustment to the workshop. With such applicants, we do not feel that our sheltered workshop can be of value. However, the experience at the workshop has given their counsellors and case workers much valuable information about them, their work limitations and their real attitudes towards work.

Latest Development

A second, and possibly more dynamic type of sheltered workshop program, is that called a Work Adjustment Centre, where emphasis is primarily on trying to move handicapped clients into industry. For such a workshop, only those handicapped clients are selected who appear to have a

reasonable chance of moving into industry with intensive vocational counselling and supervision in the workshop. The stay in such a workshop is limited to a fixed period. To be effective, however, such a workshop requires a much smaller caseload per vocational counsellor than in the "Indefinite Term" workshop.

Our most recent expansion included the establishment of such a Work Adjustment Centre. In this department, the main objective will be to try to move handicapped clients into regular industry. Since service to clients in this group will be on an intensive basis, the number accepted at any time will be restricted to ten. It is planned to limit the length of stay of clients in the Work Adjustment Centre to a period of six to nine months. Clients not moved into industry by this time will be dropped entirely or may be moved into the "Indefinite Term" Workshop. Handicapped applicants not expected to be rehabilitated into industry within the prescribed period will not be accepted into this program, although they may be eligible for the "Indefinite Term" Workshop.

A special experimental project of the Work Adjustment Centre will be the setting up of a pilot group of five mentally and/or emotionally retarded, but educable, adolescents to determine whether such services can, within a limited period of time, make them employable in regular industry. It is our hope that we can demonstrate that many young people, who would otherwise remain unemployable, can be helped to become productive members of regular industry through a professionally supervised sheltered workshop program.

Summary

What then have been the major contributions of our sheltered workshop in the rehabilitation of handicapped clients? Basically, of course, the prime contribution of the sheltered workshop has been the paid work experience provided clients. In addition, the permissive climate of the workshop has helped to break down communication barriers between many severely handicapped. It has also helped to develop, or re-develop, proper work habits and attitudes for many who had never worked previously, or had been unemployed for long periods of time. Another contribution provided by their sheltered workshop experience is the increased confidence many

clients gain in their improving ability to meet industrial production standards. From the standpoint of our counselling service, one of the greatest benefits of the workshop is the opportunity of doing "on-the-job" counselling. This has been extremely helpful in that it enables our counsellors to deal with the many problems presented by our clients almost immediately they arise, and also permits a continuing evaluation of the effectiveness of the counselling that is being given them.

Meet Some of our Workshop Clients

The following case histories reflect some of the types of individuals who have been served in our workshop:

An emotionally disturbed adolescent

A, aged 15, had been referred to the workshop by the Baron de Hirsch Institute, having previously been placed by them in their group foster home because of severe family conflict. Although he was then in grade seven, his school performance was only at the 3rd grade level. Our intake evaluation indicated that he was of low average intelligence, but possessed good manual dexterity and was well-motivated to utilize his abilities, if given the opportunity.

In the early stages he learned his tasks readily, but was quite restless and distractable, frequently asking to be given other work because he disliked the work assigned him. We, therefore, sought to compliment him for his good abilities, while stressing the importance of accepting difficult or unpleasant situations. Gradually, A developed confidence in his abilities to the extent that he was given more complex operations to perform.

Unfortunately, while he was performing well in the workshop, his actions in the foster home were such that he was discharged and returned to his parents. As soon as that occurred, he began to antagonize his co-workers in the workshop.

Simultaneously, his production deteriorated. On several occasions it was necessary to suspend him temporarily from the workshop. We then learned that his parents were not permitting him to retain his workshop earnings. With the help of the case work agency his parents were induced to rectify this, and, as a result, his production increased dramatically.

After a relatively brief additional period, job solicitations on his behalf were made and a position secured for him in a jewellery firm. He has

been on this job now for over nine months and has been functioning quite satisfactorily there.

An emigre advanced in years

B, 61 years of age, had been in Canada, unemployed, for six months, at the time of his referral to the workshop. His employability was hindered by his age, his inability to speak English, and the fact that he suffered from hypertension. Our evaluation indicated that he was of above average intelligence and manual ability, but we were uncertain whether he was able to work for a full day. Our workshop medical consultants felt that he should start in the workshop on a part-time basis.

B reacted most positively to the workshop. He reported regularly and punctually, and related quite well to his co-workers and supervisors. Additionally, he soon reached a relatively high level of production. He was checked at regular intervals by our medical consultants and, under their guidance, the number of hours he worked daily was gradually increased until he was working a full day. When it was determined that he was suffering no ill effects, employment solicitations on his behalf were initiated. At the same time, B was assigned to a variety of job operations, in order to help us determine the most suitable work for him. We succeeded in placing him as a sewing-machine operator, in which position he has proved most satisfactory.

A post-psychotic client

C had been hospitalized for mental illness. Upon his discharge, the Baron de Hirsch Institute requested that we give him a trial at the workshop. C remained in the workshop for eight months, during which time he increased his work tolerance, became used to work routines, and was able to increase his work production to an acceptable industrial level. Our supervisor recommended and obtained a regular job for him as a hospital orderly, where he has been working most satisfactorily. The Baron de Hirsch Institute and our psychiatric consultants reported that the training he received at the workshop had helped to prepare him to hold down this job.

A multiple disability case

D, 18 years of age, had been referred to the workshop by one of our local rehabilitation

[Continued on Page 16]

Ambition and Achievement

NEW LEAF ENTERPRISES

By VIRGINIA K. HARRINGTON

New Leaf Enterprises in Halifax was organized to train the handicapped of Nova Scotia in work habits and skills, and to facilitate their assimilation into industry. In May, 1960, the doors of "Handicap House" were opened and New Leaf Enterprises became a reality.

Sponsored by Junior League and Polio Foundation

The project is sponsored by the Junior League of Halifax and the Polio Foundation March-of-Dimes. It is operated by a board of five members—three from the Junior League and two from the Polio Foundation; and as ex-officio members, the manager of the workshop, the medical director of the Nova Scotia Rehabilitation Centre, the Provincial Coordinator of Rehabilitation, and the Executive Director of the Polio Foundation. The co-sponsors, the Junior League and the March-of-Dimes have provided the financial assistance to get this project started, and in equal measure, contribute to the operational costs each year.

Varied Disabilities of Clients

When New Leaf Enterprises was envisaged it was intended to serve all types of handicaps. Since it went into operation, people with disabilities from the following causes have been employed and trained in the shop:—polio, arthritis, cerebral palsy, spinal tumor, mental retardation, personality disorders, meningitis, congenital conditions, accident, heart disease, and tuberculosis. We have graduated twelve clients in this short operational period of the Sheltered Workshop in Halifax. When we say graduate we don't necessarily mean that they have learned a skill but, as a result of their employment and training in the shop, they have been conditioned for other employment and are now working. Without New Leaf Enterprises these persons would still be at home with no future.

Equipment Obtained

Equipment in the shop has been borrowed, donated and some smaller pieces purchased out

of subsidy by the co-sponsors of the shop. Through the generosity of some business firms, organizations and clubs we now have snack bar equipment and some funds for small pieces of equipment required to complete our "Office Overload" department.

Types of Work Undertaken

Projects that can be undertaken are restricted by space and equipment. We do now offer a comprehensive service in clerical lines. By combining the electric typewriter, the duplicator, folding and addressograph machines we offer a complete mailing service. The addition of a plastic binding machine has made possible the preparation of most attractive annual reports, cook books and things of this nature. Plastic credit cards are being made on the graphotype machine. The sewing machines are busy making pocket tops for dry cleaners. Manufacturing Nova Scotia tartan bridge tallies, hats and similar items makes an interesting project at the shop. Convention identification cards have been supplied to many conventions held in Halifax in the past year and these have been made by the handicapped at New Leaf Enterprises. We also have an interesting knitting project for the homebound who cannot be in the Workshop.

Manager is Polio Victim

The manager of New Leaf Enterprises is Mr. Mel Hebb who is an example of a handicapped person filling a vital role in the community. Mr. Hebb was stricken by polio at the age of nine and is now confined to a wheel chair. He completed public and high school by correspondence and then went on to take his Bachelor of Commerce degree from Dalhousie University. He was trained in the Workshop and, because of his own disability, has an understanding approach to the problems of the disabled seeking to re-establish themselves in employment through the help of the Sheltered Workshop.

[Continued on Page 22]

Marina Creations

(A review of an imaginative new service in Toronto helping a growing number of homebound handicapped persons.)

The importance of work as a physical and mental stimulant, and as a means of giving disabled persons a feeling of being part of the community, cannot be overestimated in the process of rehabilitation.

Much has been done in this regard: integration of disabled workers into many industries, operation of sheltered workshops, and training and rehabilitation centres have benefited thousands of victims of crippling diseases. Unfortunately, however, they do not help the more severely disabled who cannot go to the centres to work or to be trained. The only occupation they have is in light assembly work for industry and contract work which is delivered to them and collected. This does give employment, but it is very tedious and monotonous when you are handicapped and alone, often in a small room. It is not very inspiring work to look forward to each day, as it takes many hours and a great deal of patience to earn any worthwhile wage. Marina Creations endeavours to alleviate this particular condition.

Beginning and Development

Marina Creations came into existence in Toronto as a branch of the Homebound Department of the Society for Crippled Civilians. As Marina seemed to be the answer to effectively utilizing the services of the home-bound the Society loaned the initial \$3,000 necessary for the purchase of raw materials and the payment of wages. Their women's auxiliary provided the original nucleus of volunteers.

The guiding motive behind the founding of this new section was to make it possible for homebound workers to use inherent skills. It was obvious that, if it was not feasible for them to leave their homes to go to work, work had to be brought to them. Marina would bring to their homes complete kits that would allow the worker to make beautiful articles. These articles had to be of high artistic quality that would sell because of their intrinsic value, and not because crippled hands had made them.

If the desired results were to be obtained it was



This model wears a black lace evening hood, black evening gloves and carries a black beaded bag and a French Angora stole, all products of Marina Creations.

necessary to have a two-fold program:—(a) Rehabilitation through interesting occupation, and, (b) steady profitable marketing through high quality production.

Volunteer "Godmothers" give Guidance

Realizing that one of the most important factors in rehabilitation and uplift of morale of the homebound is "the personal touch", Marina adopted the policy of the "godmother", a volunteer who takes complete charge of one or two workers. She makes

regular visits to these individuals, delivering and collecting work and making sure that working conditions are comfortable. The volunteer ascertains that good light and proper tools are available. In addition, she will arrange for the provision of glasses if they are needed. She will further help by reporting the amounts earned. In effect, she completely looks after her workers, becomes their friend and is someone who takes time to perform many other thoughtful and kind actions. These godmothers do a great deal to help the homebound worker, such as arranging drives in good weather, taking them to the Christmas Party, the summer picnic, remembering a birthday and many other little things that come to their notice as they get to know their new friends, the handicapped workers. During the seven years of Marina's existence, this relationship has been a great source of mutual enrichment and pleasure.

High Standards Maintained

To work with beautiful materials, to produce luxury articles, and to know that they will be purchased by discriminating buyers who will select them for their artistic quality gives the worker a feeling of pride and satisfaction. The thought that the money received is "earned" through skill and diligence restores their self-confidence and self-respect. However, this is only one of the reasons for the great emphasis that Marina puts on maintaining high standards of workmanship, originality, and beauty. This is the rehabilitation side that benefits the homebound, physically and mentally. Let us now consider the marketing advantages.

To-day, the public demand for high quality gift items is bigger than ever. Jet-age travel makes it easy for the seeker of an original artistic gift to buy it from abroad if it is not available at home. Marina believes that there is an untapped wealth of skill among the Canadian homebound workers. This skill, if properly channelled, could bring unlimited benefits to them, and be a considerable addition to the nation's productive output.

Minister of Health and Welfare Commends the Program

In 1957, only two years after starting to operate, the Toronto branch sales increased to \$20,167. One worker earned \$1,461, plus a \$300 Christmas bonus. Another received \$1,232, plus

\$275 bonus. In 1960 the Marina Creations boutique sales amounted to \$12,500 in six weeks. The boutique was set-up at a fur salon by courtesy of the owner and at its official opening the Hon. J. Waldo Monteith, Minister of National Health and Welfare officiated. Among his many remarks about Marina, he said: "As you can see, I am very enthusiastic about this project. To my mind, it represents one of the best and the most heart-warming developments I have come across in a long time. . . . Marina Creations is a young idea, a young enterprise. It has achieved great things here in Toronto, in Saskatoon, and in Regina. But, this is not enough. We need a similar project in at least every major city in Canada. This, as I understand it, is Marina's objective. I wish it every possible success, and moreover, I think the idea is bound to catch on once the news gets abroad that it really works."

Realizing the great possibilities to aid Canadian homebound workers from coast to coast, the Society for Crippled Civilians released the copyrighted trade name, "Marina Creations", to the Canadian Council for Crippled Children and Adults. The name Marina Creations was chosen because of Princess Marina, the then Duchess of Kent, known for her elegance, beauty and kindness in helping the underprivileged.

The National Committee, with headquarters in Toronto, was formed. To date, branches of Marina have been opened in Saskatoon, Regina and Ottawa. Several other cities have requested information.

Forming New Branches

The following steps are necessary for the formation of a new branch. 1. A sponsoring agency which will assist the new branch by finding and screening the handicapped homebound worker, who is to become a Marina worker. They will prepare financial statements, keep accounts, and pay the workers wages, as well as all accounts for supplies. They will keep a full set of books; 2. Application to the National Committee for the use of the Marina Creations trade name; 3. Formation of a group of volunteer women who are prepared to provide leadership and assistance; 4. Appointment of a chairman whose responsibility is to see that the quality of workmanship is in keeping with the standards set by the National Committee;

5. Appointment of a treasurer and a secretary;
6. Appointment of convenors for the various departments which are as follows:

(a) Labour contact (first visit to homebound worker to evaluate skills and channel them in the best field); (b) Planning (make decisions as to what article should be produced, keeping in mind that it is of paramount importance to maintain a standard of high quality, originality and luxury for any article that will bear the Marina label); (c) Purchasing (if possible choose someone with previous experience in wholesale buying); (d) Production and training (put into reality the ideas of the planning committee, teach the worker how to do the article if necessary); (e) Examining, pricing and boxing; (f) Merchandizing (to find outlets for sales, in private homes, by invitation. Booths at large public sales. Out of town sales and through a Marina Shop); (g) Supervisor of godmothers (a person who sees that every worker is well looked after, and places new godmothers with new workers). Organizes and plans the Christmas Party, organizes and plans a summer outing; (h) Publicity (contact newspapers, magazines, T.V. and radio).

Formation of Council

On July 1, the Canadian Council for Crippled Children and Adults merged with the Rehabilitation Foundation and became known as the Canadian Rehabilitation Council for the Disabled. The centers in each province will be the sponsoring agency of any new Marina Branch.

After seven years of operation, how has Marina helped the homebound worker? The following extracts from the address of thanks to the Marina Volunteers, given by Catherine Huxtable, a muscular dystrophy victim, at the Marina Creations Christmas Party in 1956 are indicative.

"I am sure Marina Creations has been a dream come true for many of us. To have a demand for the handicraft we can do! To be paid as soon as the work is completed so that there is no anxious gamble involved for us; and to have able-bodied people arrange the whole thing, and pick-up our work from our homes! It still seems incredible to me! . . . another wonderful quality in Marina is the great confidence in us . . . that we are reliable, artistic people who deserve a worthy outlet, rather than charity . . . all I can say is: thank you from the bottom of our hearts".

[Continued from Page 12]

centers. He presented a picture of being too immature and too slow-moving for regular employment. D was reported as being mentally retarded, emotionally disturbed, and diabetic. His academic record, including four years at a school for the retarded, was consistently poor. Our evaluation indicated that he had greater potential than had been thought, with emotional difficulties limiting his actual functioning. Investigation determined that one parent was over-protective of him, while the other was over-demanding.

Initially, D functioned poorly in the workshop. He was, however, given praise whenever possible. As his adjustment to the workshop improved, pressure was placed on him to improve his work performance. Since he appeared to flourish when given attention, his work bench was placed near the supervisor's desk and a daily production quota was given him. With continuing encouragement, D met the assigned quotas.

While D continued to show improvement, it was, however, not consistent. It was then ascertained that he resented his being "babied" by his parents, who were very solicitous of him. At one point, they took him out of the workshop when they went on vacation, since he had never been taught to give himself insulin injections. This attitude was discussed with D's parents in the light of its harmful effects on his vocational adjustment. Finally, with their permission, our medical consultant arranged for him to be referred to the Diabetic Clinic of the Jewish General Hospital where he was taught to give himself injections.

As D achieved greater independence, his manner and maturity increased. After much job solicitation on his behalf, a suitable position was finally secured for him. Although his initial production on this job was quite slow, our suggestion that his employer assign him a regular production quota again served to motivate him. At last report, his employer had been finding his work satisfactory.

THE PLACE OF THE SHELTERED WORKSHOP

As more thought and investigation is going on into the place of the adult retarded in our communities the Sheltered Workshop is assuming a major role in program planning for the future. Present knowledge and experience, although limited in this aspect of the work, nevertheless tends to strengthen the idea that, in regard to services of the Sheltered Workshop, the retarded adults can be divided into three groups on the basis of service needs.

Composition of Group

The first group, according to this concept, is made up of individuals who can become almost completely self-sustaining and able to assume a normal place in the community. They may, however, need a short adjustment period before they are ready to meet the demands of competitive living, and they may need special assistance to sustain them during times of crises. The Sheltered Workshop can assist these persons in attaining their objective of independence by providing the facilities for evaluation of work potential and training in acceptable habits of behaviour, neatness of work and person, by helping them to arrive at a realistic appraisal of their own capabilities and an understanding of what an employer will expect of them in attendance, punctuality, reliability and cooperation. Through counselling and experience the Sheltered Workshop aids in the developing of good social habits and the ability to get along with fellow employees.

Extra Services Needed

The second group is made up of those individuals who will need long and intensive training if they are to become even marginally self-sustaining and will need the support of extra services to meet the demands of daily living. This long-term training can be provided in the environment of the Sheltered Workshop where, with instruction and practice, they can progress from simple to more complex tasks and where their ability to work in a disciplined atmosphere and over an extended period can be cultivated. Here they may learn to meet production standards and quotas and develop

qualities of application and industry so that they can eventually become employable in industry.

Can be Trained

The third group to be served by the Sheltered Workshop is made up of those individuals whose work potential is so low that they will never be able to work in open industry. Nevertheless, these individuals can be trained to perform simple tasks and in the Sheltered Workshop they can be trained to be productive workers and make some contribution to their own support. They will always require additional services of supervision and protection.

Most of the existing Workshop services available to the retarded are based on sub-contract work and some do some furniture re-finishing or repair work or some other type of supplementary tasks. The types of sub-contract work naturally vary with the community and are dependent on the type of business or industry in the area. In general, it consists of such things as packaging small items for manufacturing, collating reports or pamphlets, stuffing envelopes with advertising material.

Habits Developed

It has been found that the training in a particular job skill at this pre-employment stage is not so important as the habits and attitudes developed in a working atmosphere which will prepare the individual in adjusting to the demands and relationships in the world of work.

Workshop services for the retarded are still in their infancy in Canada and there is much to learn. Yet certain principles are beginning to emerge and the sheltered workshop is beginning to prove its worth as one of the resources of the community meeting the needs of this group of its citizens.

School of Rehabilitation Medicine at the University of British Columbia

The course of study at this new school includes both occupational therapy and physiotherapy and is not just a course for physiotherapists as implied in our news item in the spring issue.

A Community Enterprise
Serving The Community

OTTAWA NEIGHBOURHOOD SERVICES



Punching in for another busy day of work at Ottawa Neighbourhood Services

The "Ottawa Neighbourhood Services" has been serving the Ottawa community for nearly 30 years. Organized in 1932, it has been continuously under the very capable management of Mr. Harold M. Mayfield.

Operating under provincial charter, the Ottawa Neighbourhood Services is a self-sustaining unit receiving no grants from any source and serving all without regard to race, colour or creed. To finance the program the organization is entirely dependent upon the income derived from the sale of reconditioned materials, donated by the citizens

of Ottawa, processed by the handicapped and sold in the Services' retail stores.

Three-fold Role

The organization has a threefold role to play: 1. It provides employment, training, work evaluation and adjustment services to handicapped and needy persons; 2. It provides limited emergency relief services to the needy in conjunction with recognized welfare groups; 3. It provides clean reconditioned clothing, furniture and other household articles to persons of limited means through its own retail stores.

During the last year, the Neighbourhood Services gave full or part time employment to 118 persons with an average daily number of 68. It also provided employment to 16 homebound persons. During the year, 18 were able to return to competitive employment in industry and 18 were given work evaluation, experience and temporary employment. Ten others were referred for further medical, social and therapy services.

During the year, 618 adults and 1,789 children were provided with clothing, footwear and furniture. A number of these belonged to families who had lost their homes through fire.

Mr. Mayfield has had long and successful experience in the field of sheltered employment. His ideas and conclusions are worthy of note. In a report to the O.N.S. annual meeting, entitled "Team Work in Rehabilitation Services," he had this to say:

"It was not until a few years ago that physical restoration centres and other social agencies broadened their horizons to include the workshop as a rehabilitation tool.

"In the past, many clients came to the workshops without adequate previous rehabilitation services. Avenues of co-operation with welfare agencies have increased with benefit to all. It is at this point I would like to pay tribute to referral agencies and medical social workers who, as members of local rehabilitation teams, have been most helpful to us. We hope that before too long more effective co-operation can be arranged between all agencies covering mental health and the physical restoration field.

"Team work in rehabilitation services is a necessity. By its use the highly different skills of each team member are focussed and refocussed upon the changing needs of the client-worker.

Transitional Employment

"The new look in the sheltered employment field of service tends toward providing transitional employment, work adjustment services, etc., rather than terminal employment.

"For example, several employees referred to us by social agencies have experienced emotional and mental illness and need work adjustment

services. In our workshops they have an opportunity in an active work setting to test their capacity to work, to build up confidence and to adjust to the demands of industry. The workshop also helps the rehabilitation team to learn more about the client so they can better assist him in his struggle for independence.

Assessment Services

"During the year we have provided assessment services upon request. The principal purpose here is to assist in determining employment objectives as well as job potential. Try-outs in the various activities at the workshops provide for actual demonstration of the clients' abilities and give insight into potential abilities. These in turn can be compared with the demands of jobs in industry.

Terminal Employment

"That the older worker with limited abilities and education finds it difficult to secure employment within his capabilities is demonstrated by the number who come to our doors seeking employment to augment their pensions. We have 22 employees over 65 years of age.

"The oldest worker is 78 years old and while she values the money she earns on part-time work, it is the companionship of others and the feeling she is still needed that really counts.

"There is also the person whose handicap is so severe that he will always need sheltered employment. In our workshops these people find security, dignity and satisfaction in their work.

"In this organization, dedicated to serving people, success is counted in terms of the progress of the individuals served by our program. It is measured by the buoyant spirit, happy faces of those we have been privileged to serve. We are striving first of all to conserve human values; second, to develop human personalities and, lastly, to turn tax consumers into tax producers. The new sense of usefulness, the money in the pay envelope, the productive skills that have been reclaimed are some of the achievements of our work."

The Ottawa Neighbourhood Services is indeed a community enterprise serving the community.

SHELTERED EMPLOYMENT IN CANADA

By STEVE C. SPARLING

In order to clarify discussion on the subject of Sheltered Workshops in Rehabilitation it is necessary to outline the definitions of such sheltered workshops that seem to be accepted by those who have made a study of this problem in the past.

Definition of a Sheltered Workshop

A sheltered workshop is a voluntary organization or institution conducted, not for profit, but to carry out a recognized program for physically, mentally or socially handicapped individuals by provision of remunerative employment and one or more other rehabilitating activities of an educational, psycho-social, therapeutic or spiritual nature.

Types of Sheltered Workshops

Sheltered workshops can be divided into a number of types:—

A—*The Industrial Workshop for Sheltered Employment*

The primary aim of the industrial workshop is to provide continuing remunerative employment to persons who cannot be absorbed in the competitive labour market because of age, chronic disability, personality, emotional or behaviour problems. In addition to employment, other services of counselling, religious guidance, and help in social and personal adjustment may be provided. Medical care may be provided either in the workshop itself or through other facilities and, in some cases, board and lodging may form part of the services provided.

B—*The Industrial Rehabilitation Workshop*

The aim of the industrial rehabilitation workshop is the preparation of handicapped individuals for fully competitive employment. Remunerative employment or on-the-job training is provided and provision is made for trainees to receive, either on the premises or by agreement with local services, medical examination and continuing medical care, social and personal adjustment services, vocational counselling and, when ready, selective placement.

C—*The Institutional Rehabilitation Shop*

The institutional rehabilitation workshop is designed to train and educate—for eventual return to the community as emotionally and morally mature citizens equipped for fully competitive employment—those individuals who because of personality, emotional or behavioural difficulties have been admitted to institutions. While they are housed in the institution the workshop provides remunerative employment, medical examination and care, academic and vocational training and other social and adjustment services that may help along the process of rehabilitation.

D—*The Comprehensive Rehabilitation Centre*

The purpose of the comprehensive rehabilitation centre is similar to the industrial rehabilitation workshop, aiming at returning handicapped persons to competitive employment but also providing medical, social adjustment and vocational services within the centre as well as including work therapy and testing for work tolerances. It also may establish services for homebound individuals.

E—*Industrial Homework*

Industrial homework provides remunerative work carried out on a regular schedule as distinct from other forms of homebound programs which are mainly diversional or recreational in character.

Questions for Consideration

Having set out these major types of sheltered workshops and the purposes for which they are developed, according to their definition as agreed by the "National Committee on Sheltered Workshops and Homebound Programs in the United States", the next step is to consider some of the questions which arise when one considers this phase of our general rehabilitation program.

Firstly: How much have we accomplished to date toward developing first class programs as defined above?

My immediate response to this question is an impression I have after having read about, talked about, visited, and worked with one of our own programs in Manitoba—that we all have much to learn and to do in this area of service to the handicapped.

Certainly it is my impression that in the case of category “A” sheltered workshops, there are some quite good programs in Canada which use reclamation of salvage as the basis of their operation. Operations such as Goodwill, Crippled Civilians, etc., are accomplishing much in the way of providing sheltered employment to many who will probably not return to competitive industry. I am sure that some of these, too, will return to industry, but I feel the percentage will be small.

Despite some good programs of this type, it would seem that we are, in Canada, somewhat short of providing the setting necessary for this very large group of our handicapped to produce at their maximum capacity under sheltered conditions.

Now, what about category “B”—The Industrial Rehabilitation Workshop? Some good efforts are being made to develop programs in this category. The difference, of course, between category “A”, and category “B” is the difference in the respective aims of these shops.

In the “B” group, the primary aim is “The preparation of handicapped individuals for fully competitive employment.” Some do not make it, of course, so revert back to category “A”, a continuing program for those who cannot be absorbed into competitive industry.

Programs for category “B” individuals require a tremendous amount of study and work by people who know what they want of such a program. I am sure that most of you will agree that we are just beginning to realize the value of such programs in our total rehabilitation picture.

However, realizing the value and implementing a good program are two different things. Some programs of this nature have been started in recent years. Experience is, of course, our best teacher in this field of work but the acquiring of this experience tends to make progress seem slow. Only time can provide the knowledge we need to perfect these programs.

Category “C”—the institutional rehabilitation shop—is a category with which I am not nearly

so familiar. Some such shops, of course, do exist—more generally as part of a larger institution. I would not like to make any comment on them, other than to say that, in all probability, much could be done yet to strengthen existing programs and develop new ones.

I would suspect that, in Canada, category “D”—the comprehensive rehabilitation centre, to which is attached industrial rehabilitation services—is much stronger in the first three facets of the program (medical, social and vocational) than in the fourth, industrial rehabilitation services.

Undoubtedly, the fourth facet—industrial rehabilitation—is going on successfully in a few such establishments as Malton, but there is indeed every likelihood that more intensive work on this facet of rehabilitation centre programs in general is required.

Under category “E”—homebound industry—I am quite sure that this facet of a total rehabilitation program must receive a great deal more attention and work before we can be satisfied that homebound people with the capacity to produce are being given anything like a fair opportunity to make themselves at least partially self-sustaining.

Development of Programs

From these remarks I am sure you have gathered a somewhat gloomy picture of the status of sheltered workshop programs in Canada. In covering these types of workshops generally, I do not want you to underestimate the amount of fine work being done in this area of rehabilitation because, contrary to the tone of my general remarks, a great deal of thought and effort is going into the development of such programs day by day. It is a difficult struggle, for there is not a great deal of precedent to follow.

What appears to me to be more significant than any actual development to date is the growing awareness and understanding of the need for such programs by rehabilitation workers in general. This was not apparent even ten years ago. Definite signs of movement are noticeable in many spots in Canada, and there appears to be quite a firm move toward accepting the people who need these programs as an integral part of our responsibility in the overall rehabilitation program.

I have followed the definitions set out in the handbook simply to bring attention to the various

categories of programs in this area of rehabilitation that should be considered. I would like to emphasize, however, that each locality has its own peculiar problems with which it must deal, and existing programs on which to build.

Meeting Future Needs

I am very sure that in many cases the eventual program that is developed will not follow these definitions to the letter. Rather, a combination of needs in smaller localities, where a facility for each classification is out of the question, will inevitably mean a combination of programs in the one sheltered workshop facility.

The important thing I would like to re-emphasize in conclusion is this:

There are some good programs in existence, but none which cannot be improved; secondly, there are several young programs in the development stages which show real promise for the future; thirdly, there appears to be an overall awareness of this pressing aspect of a total rehabilitation program growing all across Canada. I have every confidence that before many years have passed, the facilities for dealing with this large group of our handicapped will grow quickly.

My remarks necessarily have been very general on a subject which on closer scrutiny becomes quite complex.

What are our goals in Canada for this group of people who may be defined as:

"Severely handicapped people who cannot be rehabilitated through the usual procedures and facilities established for general community use, but who require additional specialized

facilities, and a combination of services over an extended period of time?"

Not every severely disabled person needs the services of a sheltered workshop, but there are many of the following who do:

The deaf, the deaf-blind, the blind, those with orthopaedic and neuromuscular disabilities, the epileptic, the cardiac, the tuberculous, the mentally deficient, and the mentally disturbed.

Surely we have one goal to keep in mind—a very simple one—to assess this problem carefully in our own communities and start building a program of the type most needed.

The late Steve C. Sparling was a well-known and respected authority in the rehabilitation field in Canada. At the time of his untimely death last December he was Executive Director of the Society for Crippled Children and Adults in Manitoba. He was always ready to share with others his knowledge and experience in various aspects of work with the handicapped. In 1960 Mr. Sparling participated in a discussion on the "Goals of Rehabilitation in Canada" which was part of the program of the annual meeting of the Canadian Council for Crippled Children and Adults. The meetings were held that year in New York in conjunction with the World Congress of the International Society for Rehabilitation of the Disabled. Steve Sparling's contribution dealt with sheltered employment.

Shortly before his death Mr. Sparling sent us a copy of the text of his remarks and we are very happy to be able to publish them at this time when the matter of sheltered employment and sheltered workshops is receiving increasing attention in rehabilitation planning.

Change of Address

Please notify "Rehabilitation in Canada," Civilian Rehabilitation, Department of Labour, Ottawa, Ontario, if you have changed your address.

[Continued from Page 13]

Volunteers Play Vital Role

The Junior League volunteers play a vital role in the operation of the workshop. It is true to say that New Leaf Enterprises could not operate on its present budget without these volunteers.

The future of the Workshop is mirrored by the past. In two years, starting from nothing, we have built an operating organization, equipped it, and provided employment and training for many handicapped. Given continued interest and sup-

port, it will continue to fill a very necessary and real place in the total rehabilitation of the handicapped in Nova Scotia.

It has been our experience that a sheltered workshop is essential to the total rehabilitation of the handicapped. However, the establishment of such a facility requires money and interested and intelligent volunteers who will devote many hours to the organization, operation and management of the project.

IMPROVING THE PROGRAM AND IMAGE OF THE SHELTERED WORKSHOP

By DARREL J. MASE, Ph.D.

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(In this article, reviewed here, Dr. Mase brings up some points of interest worthy of careful consideration in planning any developments in the field of sheltered employment.)

Dr. Mase states that workshops have a vital role to play in the rehabilitation process and that his role will become even more important in the future.

However, in his opinion, there is a possibility that the terms "workshop" and "sheltered workshop" are creating an unfavourable impression in the minds of employers and the community. He says these terms carry the connotations that these programs are "shelters" for the disabled and only secondarily a service to the community and to the individuals working in such programs. The term "sheltered workshop" somehow implies the concept "terminal"—a dead-end shelter. We get under a shelter to get out of the rain and that is where we stay until it stops raining. Men and women with a disability get into a sheltered workshop and that is where they may stay as long as they are disabled, no matter what their potential.

Developing Image

The terms "sheltered," "workshop" and "terminal" may be developing a figure image which adds to the difficulty in making the desirable transition to competitive employment. Prospective employers may be getting the wrong idea. Clarification of terms would assist workshop managers and workers to better understand the objectives of their efforts. Such clarification would assist managers to hold more strictly to specific programs they should be directing.

Discussing the diversity of sheltered workshop programs and the endeavour to provide a variety of services, he questions whether the workshop can create the proper idea in the minds of prospective employers if it tries to combine terminal employment along with training program and evaluative procedures and also comprehensive medical, vocational, psychological and social services.

Dr. Mase is of the opinion that medical and health-related services should not be provided by the workshops except in unusual circumstances. Some workshops may be part of a rehabilitation centre and, as such, have access to medical and related services as required, but they are not provided by the workshop itself. It is important that these facilities should be available in the community for workshop trainees or workers, but duplication of services should be avoided.

He says: "Physical therapy, occupational therapy, psychological evaluations, medical evaluations, treatment and related health services should be provided in hospitals, rehabilitation centers, and other such settings. We should no more have medical and health-related service in a workshop than we would have industrial medicine in a comparable industry or business. By providing all of the medical and health-related services in the workshop we are frightening the prospective employer, who may not feel he can accept these individuals from the workshop into his employ because of all these health services which seem essential to the prospective employee but are unavailable in his industry or business".

Dr. Mase recommends that the words "trainee" and "employee" are more appropriate terms than "client" as a word for those persons who are receiving services at the workshop. The word "client" is a substitute for "patient" employed by psychologist, speech pathologist, and vocational rehabilitation counsellors and the prospective employer is not interested in employing "patients".

"Let us call these people what they are," says Dr. Mase, "and this may help to open doors to employment. They are trainees and employees".

Open to Debate

Whether a workshop can be self-supporting is open to debate. If the objective is employment and preparation for competitive industry it is very doubtful if the workshop can be self-supporting. Again we quote from Dr. Mase's article: "Could any industry or business exist very long without subsidy if its objective were to find other employment for its most mature, stable, productive employees?"

After discussing the types of work done in workshops and the values of combining contract work with other types of work, as well as the necessity for meeting standards of production and quality, he suggests the advisability of dividing the workshop program into a training section and a production section. He also discusses the value of combining various types of disabled in the program since this leads to a greater variety of ability and more complicated types of work can be undertaken.

Dr. Mase believes that planning on a regional basis could help to develop programs on a sound business basis that could offer the variety of services needed. He feels that a high level procurement specialist could seek sub-contract work for workshops and distribute it to workshops in the region on the basis of their ability to meet specified standards. A marketing specialist could be employed to seek sales outlets for the manufactured products from shops doing this type of work. This would help to do away with the necessity for the workshop director to be shop foreman, public relations director, training director, sales representative and procurer of contract work.

He feels that homebound employment can best be provided by using the staff and facilities of the sheltered workshop to distribute and collect such work as can be done by those persons who are able to work but are unable to go to the workshop.

Dr. Mase closes his article by outlining the role of the community in the provision of sheltered employment and indicates the importance of community acceptance and participation if the program is to accomplish its purpose. He emphasizes the need for the community to recognize that the sheltered workshop will not likely be self-supporting and will need continuing community support, but this, he points out, is much

more economical than having these individuals continuously dependent on public assistance.

About the Author

Dr. Mase is Dean of the College of Health Related Services, J. Hillis Miller Health Centre, University of Florida, Gainesville. He is consultant to the United States Office of Vocational Rehabilitation. Dr. Mase was recently appointed to the Panel on Mental Retardation by President Kennedy.

AN AGENCY IS BORN

Sponsored by the Montreal Council of Social Agencies, an experiment in recreation for the handicapped has led to the formation of a new agency, Recreation for the Handicapped Inc.—Loisirs Pour Handicapés Inc.

In 1957, the Montreal Council of Social Agencies received a request from several of the city's health agencies concerned with the severely handicapped. They were frankly worried because there was so little recreation in which the severely handicapped could participate. A committee was set up to see what existed in the way of recreation in which the handicapped could take part. It organized meetings of those who were concerned with the welfare of these people—health agencies' personnel, doctors and interested citizens. The result was that the Montreal Council of Social Agencies was asked to undertake a pilot project to demonstrate what could, and should, be done. The results are described in a booklet entitled, "An Agency is Born", published by the Montreal Council of Social Agencies, 1040 Atwater Avenue, Montreal 6.

The booklet describes some of the projects undertaken and how existing facilities were utilized. It tells of the part played by volunteers and how the results demonstrated the need for a continuing and expanded program to bring the benefits of recreation to all the handicapped. The new organization, Recreation for the Handicapped Inc., Loisirs Pour Handicapés Inc., by special charter from the Government of the Province of Quebec has been established to bring to the handicapped of Montreal the benefits and pleasures to be found in recreational activity.

FIRST MEETING OF THE NATIONAL ADVISORY COUNCIL ON THE REHABILITATION OF DISABLED PERSONS

Under the chairmanship of Brigadier James L. Melville, the newly-appointed National Advisory Council on the Rehabilitation of Disabled Persons met for the first time in Ottawa, May 14 and 15.

This meeting brought together representatives of provincial governments, voluntary agencies, the medical profession, the universities, organized employers and organized labour along with federal government officials. This council was established to advise the Minister of Labour on matter relevant to the vocational rehabilitation of disabled persons under the terms of the new Act respecting the vocational rehabilitation of disabled persons and the co-ordination of rehabilitation services which went into effect on December 1, 1961.

Primary Purpose

As this was the first meeting since the passing of the new legislation, its primary purpose was to study the terms of the new Act and the Agreements now being concluded with the provinces, as well as the various related government programs. Officers of the Departments of Labour, National Health and Welfare, and the National Employment Service described their programs and the ways in which they related to the development of a comprehensive rehabilitation program in Canada.

Dr. George V. Haythorne, Deputy Minister of Labour, speaking on behalf of the Ministers of Labour and National Health and Welfare expressed their regrets for their absence and brought good wishes from them for a successful meeting. He commended the membership of the Council for their contribution, stressing the important role of the Council in advising the Government on the implementation and development of the Federal-Provincial vocational rehabilitation program.

Dr. Haythorne pointed out that the results of the rehabilitation program to date have shown that, with help of the right kind, disabled persons were often able to take their place in the community and contribute to the economic life of the

country rather than remain dependent on public or private assistance. He felt it was important to identify clearly the methods and techniques required to accomplish this. For this reason he was pleased that provision had been made in the legislation for research. Through research the types of diagnoses and counselling required to produce desired results were revealed. He suggested that the methods used in rehabilitation could well be extended with considerable benefit to all those who were handicapped by social and economic problems.

Report of the National Co-ordinator

Mr. Ian Campbell, National Co-ordinator, Civilian Rehabilitation, outlined the progress that had taken place in developing rehabilitation services in Canada. He commented on the high standard of services that had been developed and expressed the hope that the new legislation would lead to expansion of these services while maintaining the high standards.

This new legislation has been developed with the advice of provinces, voluntary organizations and federal departments. It lays a solid base on which to develop a comprehensive national program.

Mr. Campbell reported that the national office had co-operated in three workshops or seminars during the past year. One, at Banff, and one at Shediac provided opportunities for personnel from the Western Provinces and the Maritimes to meet for discussion and study of matters related to their programs. A seminar for government and voluntary agency officials from the prairie provinces was held last October at Falcon Lake in Manitoba. In addition, rehabilitation staff had attended many meetings and discussions. They had addressed interested bodies, lectured at universities, made television appearances and radio broadcasts as well as assisting in staff-training programs as requested by provinces.

Continuing Increase

A continuing increase in medical facilities necessary to rehabilitate the disabled was reported. New training schools for physiotherapists and occupational therapists had been opened in Manitoba and British Columbia. Referring to statistical studies and reports which were provided to the Council for study, Mr. Campbell drew attention to the increased number of persons who had received vocational training. There had been an increase in the staff employed in the provinces, more Special Placement Officers had been employed and this had been reflected in the number of disabled persons who had been returned to vocational usefulness. Attention was drawn to the small number reported as rehabilitated in comparison to the known incidence of disability. The relationship between the duration of disability and the period required for rehabilitation was cited. The importance of early referral to rehabilitation services was stressed.

Mr. Campbell also noted that on the basis of a study of reports submitted, it was becoming evident that early referral to rehabilitation services should be made in all cases where disability resulted, even when it appeared that disabled persons were apparently able to plan their own program of vocational readjustment. Not only did this help the disabled person in the initial stages to assess his plans realistically with trained advisers, but it gave him the confidence of knowing he had the support of competent authorities, as well as a resource to call upon, if his plans did not work out as expected.

Mr. Campbell referred to the heavy financial burden of dependency and indicated the need to increase efforts to reduce this. In the case of the disabled we had gained the knowledge required to reduce this substantially.

"We have in the Vocational Rehabilitation of Disabled Persons Act," said Mr. Campbell, "a firm declaration of the support which the Government of Canada can give to provincial programs."

He went on to say that many of the barriers to an adequate program had been removed. Hospital insurance had helped make extensive use of treatment facilities available, vocational training programs had been expanded and imagination had been applied to the types of training which could be given with a view to gain-

ful employment. Additions had been made to the Special Placements staff of the National Employment Service and employment liaison officers had been appointed in a number of provinces. The new welfare grants recently announced would be a further assistance to the program.

The National Co-ordinator emphasized the need for more adequate staff and an expansion of facilities for treatment and assessment. Greater use should be made of those facilities for vocational training that are expanding so rapidly at the present time.

"There is a need to step up placement efforts and invite a more vigorous participation of both labour and management who have given assurances of their interest and support in the past," he added.

European Programs

Mr. Campbell commented on rehabilitation programs and facilities he had observed in European countries, from which he had just returned. While standards of services in Canada were high and compared favourably with those observed in these countries, the quantity of services was much smaller in Canada. The European Social Charter placed certain obligations upon those who had signed, that is upon the nations within the common market area. The charter affirms the right of each individual, disabled or not, to vocational guidance and vocational training as required. It was not surprising, therefore, that the whole concept of rehabilitation was more broadly established than in North America. In a number of these countries, facilities and services were much more adequately equipped and, in comparison to our situation, lavishly staffed. Consequently, the numbers of those rehabilitated in relationship to the total population was larger than in Canada. The trend in all these countries was to extend the benefits of vocational rehabilitation to all types of handicapped persons, including not only the physically handicapped, but also those who, for one reason or another, were unable to provide for their own support.

However, in these countries the responsibility for co-ordination of services was not placed definitely with one authority. Officials thought that many delays could be eliminated if, as in Canada, co-ordination of services was provided

or more adequately. So, perhaps, while learning much from these countries, we had something to contribute in return.

Expansion of Vocational Training Services

Mr. C. A. Ford, Director, and Mr. R. H. MacCuish, Assistant Director, Canadian Vocational Training Branch gave details of the expansion of training facilities all across the country. As a result, an additional 112,000 students may now be accommodated at any one time in the technical and vocational schools and institutes.

One development of considerable importance with which they dealt was the introduction of a training plan known as "Basic Training for Skill Development". This provides instruction in such essential subjects as language skills, mathematics, and science. It is designed to help those persons who lack the academic standing required for training that would benefit them as they seek to enter the world of work or upgrade themselves therein. Statistics were provided showing the numbers of disabled persons who received training under Program 6, the special program for disabled persons, and also the types of training which had been provided.

Health and Welfare Aids Rehabilitation

Dr. J. H. Horowicz and Dr. O. Hoffman of the Department of National Health and Welfare described the assistance available through the Medical Rehabilitation Grant. They also pointed out how the other Health Grants and the Hospital Insurance program were utilized in making available many facilities and services required for medical restoration. Assistance in training of medical and other health services personnel is also provided under the Health Grants program. Dr. Hoffman also gave details on the Blindness Control Program which has been in operation since 1948. Since the inception of the program 843 persons have been treated, 652 so successfully that they were no longer blind and most of the remainder obtained better guiding vision.

Mr. John Osborne, of the same Department, reported on federal-provincial assistance programs. These include the Disabled Persons Act, by which the federal government shares with the provinces in providing assistance to the totally and permanently disabled, and the Unemploy-

ment Assistance Act whereby unemployed persons can receive assistance. This latter Act is also financed on a matching basis and is administered by the province. A new Welfare Grant has recently been announced which will provide for research in the welfare fields and, through training grants and scholarships, assist in the training of personnel to work in various types of welfare work.

Placement Services

Mr. C. A. L. Murchison, Commissioner of the Unemployment Insurance Commission, reported on the operation of the National Employment Service in the selective placement of the disabled. In larger centres full-time special placement officers were employed. In smaller areas, officers were trained to provide this specialized service in addition to other duties. Expansion of the special placement service had taken place as need had indicated. During the past four years local Employment Offices had increased from 193 to 201. In 1958, 26 offices had 167 full-time special placement officers. Today the number had grown until 110 offices have 259 full-time special service officers. Special training courses were provided to train these officers in the complex duties of job counselling and selective placement. This instruction was provided by special courses, area schools and training on the job and was a continuing process.

Another development reported was the appointment of employment liaison officers. These officers provided liaison between the local offices of N.E.S. and the provincial rehabilitation authorities. The liaison officer serves as a member of the rehabilitation assessment team, advising on the employment and training aspects of individual plans being developed for handicapped persons and helping to evaluate the employability of rehabilitants.

Mr. Murchison emphasized that in many cases the physical limitations of the disabled persons were not nearly so significant a deterrent to their employment as the lack of education and training. With the increasing use of automation, requirements for top physical condition are lessened but the necessity for a sound educational background becomes increasingly important.

Mr. Noel Meilleur, Assistant Co-ordinator, Civilian Rehabilitation, reviewed developments in

the provinces, noting that greater emphasis had been placed on case finding and the establishment of efficient and practical assessment procedures. He presented a review of rehabilitation statistics comparing the past year with previous years.

Considerable time was devoted to a detailed examination of the new Vocational Rehabilitation of Disabled Persons Act, along with the Agreements being entered into by the Provinces with the Federal Government.

The representatives of the various branches of government involved in the program answered questions that arose regarding the implementation of the agreements and helped clarify many details of services available and procedures to be followed in making best use of them.

Members of Council expressed appreciation for the efforts that had gone into the development of rehabilitation services in Canada and gratification at the progress that had been made since the Toronto Conference of 1951. Concern was shown because the services were not yet reaching all who could benefit. The feeling was, however, that with the passing of this new legislation, the result of much effort on the part of government and voluntary agencies, an important milestone had been reached. The Council expressed its hope that with this Act an instrument was available to facilitate the task of expanding services to the point where every disabled citizen was assured of receiving all the assistance required for his particular needs.

Unlimited Skills Incorporated

(This firm, set up to give employment to the severely disabled, has provided our modern society with a practical demonstration of the capability of handicapped persons)

Unlimited Skills, Inc., founded six years ago in Montreal to provide employment for the handicapped, has long since proved its value. The firm carries on work such as mechanical and electrical assembly, light machine work, hand packaging and direct mailing.

Starting with 11 employees in 1956, the firm has outgrown its 8,000-square-foot factory in the north end of Montreal and recently moved to

larger quarters providing another 3,000 square feet of space.

Financial profits of the firm may not be large but its real profit is incalculable. In its six years of operation Unlimited Skills has given work to more than 200 persons, paraplegics, amputees, arrested TB's, some with deformities, aged persons, blind, mentally retarded, or victims of polio, multiple sclerosis, muscular dystrophy, cerebral palsy or epilepsy.

Line employees are paid competitive wages of 70 cents and 80 cents an hour. Some in the machine shop receive as much as \$1.60 to \$1.70 an hour. In addition, about 40 employees have received a total of \$3,500 under a profit sharing plan.

Already, the enterprise has saved taxpayers more than \$35,000. Collectively, the employees have paid more than \$15,000 in income tax. Disabled persons allowances costs have been reduced by more than \$20,000.

Unlimited Skills is not a sheltered workshop. Employees must be able to fill job requirements and meet production schedules. Especially in the highly competitive packaging field, which accounts for about 45 per cent of the work of the factory, operating costs must be strictly controlled.

Forty-five disabled persons have been returned to "normal" industry. In addition to providing employment, one of the objectives of Unlimited Skills is to demonstrate to industry the capabilities and productivity of the physically handicapped.

[Continued from Page 7]

sheltered employment in the rehabilitation process. The concept of a sheltered workshop is not of itself a rehabilitation agency. It becomes a part of the rehabilitation process in much the same way as an industry does when it accepts disabled people for training on the job or for work experience. The sheltered workshop can, I submit, only function effectively as a part of the rehabilitation process to the extent that there is a well integrated rehabilitation program in the community.

People and Events. . . .

The Baker Foundation Established

After 42 years service to the blind in Canada, Colonel E. A. Baker, O.B.E., M.C., Croix de Guerre, B.Sc., LL.D., retired at the end of June as Managing Director of the Canadian National Institute for the Blind.

Colonel Baker has devoted most of his life to the development of services for the blind and to programs of prevention of blindness. In recognition of his outstanding service, the C.N.I.B. has set up the E. A. Baker Foundation for Prevention of Blindness. It was fitting that this should be done during Prevention of Blindness year, a year dedicated to directing public attention to visual health. This program is at present under way in 109 member countries of the World Health Organization.

The Baker Foundation will assist in many prevention of blindness projects which have been of great interest to Colonel Baker over the years. It will provide fellowships and scholarships to encourage young doctors to study ophthalmology. There is an ever-growing need for more eye doctors in Canada. At present there are only 250 certified ophthalmologists in this country. A grant of \$3,000 to the University of British Columbia for this purpose was made during the past year. Ophthalmic research will also receive support from the Foundation as well as provision of special equipment required by eye specialists. During the year the C.N.I.B. made a grant of \$4,000 to the University of Toronto to supply four microscopes to be used in teaching in the Department of Ophthalmology at the University. This is in addition to two fellowships of \$2,000 each presented annually by the National Council and the Ontario Board of Management. Grants to encourage and assist nurses to take special training in ophthalmic nursing will be provided by the Foundation.

The Foundation will provide research grants to the Eye Bank of Canada to study ways of restoring sight to more blind Canadians. Some 600 persons have already benefitted from this service. The Low-Vision Clinic in Toronto has improved the vision of many Canadians who could not be helped by ordinary lenses. The

Baker Foundation will aid the expansion of this service. Through special grants to these and other services of prevention, the Baker Foundation will aid in the promotion of visual health across the country.

Although Colonel Baker worked untiringly for the betterment of services for the blind in Canada, he did not confine his interests to his own country. Colonel Baker is now serving his third term as President of the World Council for the Welfare of the Blind which seeks to aid the sightless in more than 40 countries. He was actively interested in the formation of the Royal Commonwealth Society for the Blind, London, England, which now serves the blind in the underprivileged countries of the Commonwealth. The Baker Foundation will assist, to some degree, prevention of blindness programs now under way in underdeveloped countries of the world.

Blinded himself during World War 1, Colonel Baker has maintained an active interest in veterans' affairs. He is Honorary Chairman of the National Council of Veterans Association in Canada; Honorary President of the War Pensioners of Canada; a Life Member of the Canadian Legion and the Army, Navy, and Air Force Veterans in Canada. He was Vice-President and later Secretary of the Sir Arthur Pearson Association of War Blinded for over thirty years.

Colonel Baker was the first recipient of the Helen Keller Award for outstanding leadership at international levels. The award was presented by Helen Keller herself in New York in 1960.

With the passing of the Vocational Rehabilitation of Disabled Persons Act, the Minister of Labour appointed Colonel Baker as a member of the National Advisory Council for the Vocational Rehabilitation of Disabled Persons as a representative of the voluntary agencies. During the past ten years Colonel Baker had given outstanding assistance to the Government of Canada in the development of plans for vocational rehabilitation of disabled persons.

Reader's Digest Adds \$500 All-Canadian Award to International Plan

Mr. Douglas How, Managing Editor of the Reader's Digest, has announced an all-Canadian award of \$500 to be added to the present Inter-

national Rehabilitation Awards Plan sponsored by the Reader's Digest Foundation.

The Canadian Award committee will be set up under the Canadian Council for Crippled Children and Adults and the chairmanship of Mr. Frank McIntosh, President of the Pepsi-Cola Co. of Canada, Ltd., Montreal.

International Awards

The Reader's Digest Foundation, in co-operation with the International Society for Rehabilitation of the Disabled, has established the International Rehabilitation Awards to promote rehabilitation programs for the physically handicapped throughout the world. Two general awards of \$2,500 and \$1,500, and five regional awards of \$500 each will be presented to those organizations which have made the most substantial progress in creating and expanding rehabilitation programs within their communities during the two-year period 1961-62. These seven awards will be presented at the Ninth World Congress of the International Society in Copenhagen in June, 1963.

The awards will be open to all societies, associations or professional groups concerned wholly, or in part, with the rehabilitation of the disabled, in any country of the world. Winners will be those organizations which have conceived and developed the best rehabilitation programs within their own communities during the two-year period January 1, 1961 to December 31, 1962. These programs may be in any field affecting welfare of the disabled.

In making its decisions, an International Selection Board, comprising seven experts in the field of rehabilitation, will give particular consideration to: (1) rehabilitation services existing in the community in 1960; (2) voluntary leadership provided by the organization to promote an understanding of the needs of the handicapped within the community; (3) means employed to provide the needed services; (4) action taken by the organization to remove existing prejudices hindering the development of medical, social, educational and vocational services for the handicapped; (5) efforts made in the development of employ-the-handicapped programs, educational services and medical programs established for crippled children. Since judging will be based on the status of services and facilities existing in the com-

munity prior to 1961, those organizations applying from the smaller or lesser developed nations can compete on a level with those from the wealthier nations.

New Award Presented

The second annual meeting of the Co-ordinating Council on Rehabilitation (Saskatchewan) was the occasion for the presentation of the newly-established Lieutenant-Governor's Citation. The award, to be presented annually, is intended to give suitable recognition to those Saskatchewan employers who best typify the principles and practices of employing the disabled. Award-winning employers may be selected from any trade, business or profession and the merit of a small firm employing possibly one handicapped person will be judged on an equal basis with a large concern employing many.

Receiving the awards for the first time from Lieutenant-Governor F. L. Bastedo were Harry Landa, owner representing "Doc" Landa's Auto Body Works; A. J. E. Child, President, representing Intercontinental Pork Packers, both of Saskatoon; and Sherman Smith, Manager, as representative of Automotive Remanufacturing Ltd., of Regina.

The names of the employers receiving the citation each year will be inscribed on an "Honour Roll" in the form of a permanent scroll and displayed in appropriate places throughout the province.

Honoured on Retirement

Mr. Roy Campbell, who represented employers on the National Advisory Committee for Rehabilitation of the Disabled, was presented with an illuminated scroll by the members of the Montreal Council for the Guidance of the Handicapped at their meeting on June 19, 1962. This marked the retirement of Mr. Campbell as chairman of the council and paid tribute to his years of service to the council in its efforts to develop services for the handicapped of Montreal and district. His leadership has contributed greatly to the effectiveness of the council and helped it to its present position of prestige and influence in community efforts for the handicapped. Mr. Campbell, while relinquishing the responsibilities of leadership continues his interest in the work of council and has accepted the position of honorary chairman

Now, as a member of the new National Advisory Council, he continues to lend his advice and support to the Government in its efforts to develop effective plans for the vocational rehabilitation of the disabled in Canada.

Dr. Wherrett Honoured

Dr. G. J. Wherrett, for 29 years Executive Director of the Canadian Tuberculosis Association, was honoured at the recent annual meeting of the Association in Edmonton with the presentation of a cheque to buy a painting of his own choice. Dr. Wherrett's retirement from this position was to be effective from July 1, 1962. Dr. Wherrett will, however, continue to act as Director of Research.

Dr. Wherrett has devoted most of his life to the treatment and prevention of Tuberculosis. Following three years in the Tuberculosis Service of the Department of Health in New Brunswick he went to London, England, for Post-graduate study. Upon his return to Canada, he was Assistant Superintendent of the Saskatchewan Anti-Tuberculosis League before coming to the Canadian Association in 1933.

Dr. Wherrett has served as a member of the World Health Organization's expert committee on Tuberculosis and on the Canadian Medical Team visiting India in 1957 under the Colombo Plan.

He acts as a consultant to the Department of National Health and Welfare and is a member of the Canadian Pensions Commission.

In 1961 Dr. Wherrett was elected President of the International Union against Tuberculosis and his knowledge and experience will continue to be available to help the world-wide program to fight tuberculosis.

H. H. Popham Receives Award

The C. D. Taylor Award for outstanding service to crippled children in Canada was presented to Mr. H. H. Popham of Ottawa at the 25th anniversary banquet of the Canadian Council for Crippled Children and Adults in the Chateau Laurier in Ottawa. Mr. Popham, a past president of the Council, is now President of the International Society for Rehabilitation of the Disabled. This is only the second time the award has been made. Mr. Popham also received a past president's award, along with six other recipients.

Appointed to C.A.R.C.

The Government of Saskatchewan has announced the resignation of Dr. G. Allan Roeher as Provincial Co-ordinator of Rehabilitation to accept the position of executive director of the Canadian Association for Retarded Children with headquarters in Toronto. The resignation becomes effective at the end of October.

Dr. Roeher has contributed greatly to rehabilitation both in Saskatchewan and the country at large. His vision and leadership led to the organization of the Co-ordinating Council on Rehabilitation in Saskatchewan and to the developing of needed services which promise well for the future. Dr. Roeher will now concentrate his efforts on the developing of a total program for the largest and most seriously disabled group in Canada.

Forty Years Service to the Disabled

The International Society for Rehabilitation of the Disabled in 1961 celebrated the 40th anniversary of its founding. Originally known as the International Society for Crippled Children it has twice changed its name. In 1939 it became the International Society for the Welfare of Cripples but in 1960 adopted its present name as a reflection of the broadening of its interests and a more dynamic approach to the problems of disabled individuals.

A Correction

We regret the typographical error whereby the word "statistically" was substituted for "statically" in Dr. Sypher's article, "General Theory of Low Back Pain", which appeared in our spring issue.

We are grateful to Dr. Sypher for bringing the matter to our attention and for providing the following explanatory comments:

"Despite recent advances in space travel, most of us are destined to be earthbound in a constant battle with gravity. Each of us presents a flexible column on a moveable base which may be taken as an example of a system of forces, balanced under gravity, and the distortions of the system may be considered within the scope of a branch of mechanics known as statics.

"Mechanical factors place fairly precise limitations on the system, even though the human body introduces additional factors of a biologic and social nature. Because mechanical factors prescribe the framework within which other changes may take place, it is appropriate to designate a class of bodily distortions, where mechanical factors obviously loom large, as *statically* determined—not 'statistically' determined, as appears in error at the top of page 12, right hand column."

Wheel Chair Contest

A \$5,000 award is being offered by the President's Committee on Employment of the Physically Handicapped and the National Inventors Council for the successful invention of a stair-climbing wheel chair.

Factors to be considered in the invention of the chair are weight of occupant (approximately 200 lbs); weight of chair (50-75 lbs. maximum), collapsibility, width of chair (maximum 25 inches) turning and climbing ability, propulsion system using minimum arm strength of 10 lbs., safety, cost (\$500 maximum retail) and obviation of special ramps, mechanical contrivances, or electrical outlets in buildings.

All entries should be submitted prior to Dec. 31, 1962, to National Inventors Council, U.S. Department of Commerce, Washington 25, D.C. Further information and background materials are also available from the Council.

University Post to Study Retardation

Establishment of a visiting professorship in mental retardation at the University of Toronto was recently announced.

The post will be held by a series of experts in the field of mental retardation, the first of whom is Dr. T. L. Hilliard, a British psychiatrist and specialist in mental deficiency. He will spend six months at the University commencing his term on May 1.

The professorship is assured of being financed for three years by an Ontario Association for Retarded Children Telethon Fund grant.

Rehabilitation Counsellors Meet in Halifax

In May, counsellors of the Rehabilitation Division of the Department of Public Health in Nova Scotia met in Halifax to discuss the recently-signed Vocational Rehabilitation of Disabled Persons Agreement, through which the federal government shares with the province the cost of rehabilitation services. In his report to the conference, Mr. Frank G. Wellard, Provincial Co-ordinator of Rehabilitation, indicated that 106 severely handicapped persons were returned to vocational usefulness in 1961. During the year, officers of the division made 876 home-counselling visits and conducted 597 office interviews with

disabled persons. Special trade training was given to 126 handicapped persons, allowances were paid to 34 persons while they received out-patient treatment at the Nova Scotia Rehabilitation Centre and artificial limbs or braces were supplied to 20 others. Vocational training of disabled persons, job placement and workmen's compensation were also subjects of reports by representatives of these services.

Rehabilitation Offices In Canada

NATIONAL OFFICE

National Co-ordinator,
Civilian Rehabilitation,
Department of Labour,
OTTAWA, Ontario.

PROVINCIAL OFFICES

Provincial Co-ordinator of Rehabilitation,
Department of Health,
Post Office Box E5250,
ST. JOHN'S, Newfoundland.

Deputy Minister,
Department of Welfare and Labour,
CHARLOTTETOWN, Prince Edward Island.

Provincial Rehabilitation Co-ordinator,
Department of Public Health,
Post Office Box 488,
HALIFAX, Nova Scotia.

Director and Co-ordinator of Rehabilitation,
Department of Health,
FREDERICTON, New Brunswick,

Physically Handicapped Division,
Department of Youth,
9175 St. Hubert Street,
MONTREAL 11, Quebec.

Provincial Co-ordinator of Vocational Rehabilitation,
Department of Public Welfare,
85 Eglinton Avenue East,
TORONTO 21, Ontario.

Provincial Co-ordinator of Rehabilitation Services,
Department of Health,
Room 615, Norquay Building,
WINNIPEG 1, Manitoba.

Provincial Co-ordinator of Rehabilitation,
Health and Welfare Building,
REGINA, Saskatchewan.

Department of Public Welfare,
109th Street and 98th Avenue,
EDMONTON, Alberta.

Attention: Mr. John G. Fricke.

Rehabilitation Co-ordinator,
Department of Health Service and Hospital Insurance,
828 West 10th Avenue,
VANCOUVER 9, British Columbia.

ALL—WINTER

1962-63



Rehabilitation **IN CANADA**

Published in the interests of Canada's Disabled by ...

CIVILIAN REHABILITATION

Department of Labour Canada

CONTENTS

Page

- 4 Increasing Training Opportunities
 - 7 A Glance in the Mirror—REHABSMANSHIP
 - 9 Vocational Training and Vocational Rehabilitation
 - 12 Training—What it means to Blind Canadians
 - 14 College Life from a Sit Down Point of View
 - 16 Older Workers—Training and Education
 - 19 I Saw a School Come to Life
 - 21 Partners in Living—Special Education and Rehabilitation
 - 22 I. L. O.—Recommendation on Vocational Training
 - 24 Training-On-The-Job Opportunities
 - 28 People and Events
-

This bulletin is prepared with the cooperation of the Department of National Health and Welfare, the Department of Veterans Affairs, the Unemployment Insurance Commission and governmental and private agencies interested in the rehabilitation of Canada's disabled.

ROGER DUHAMEL, F.R.S.C.
QUEEN'S PRINTER AND CONTROLLER OF STATIONERY
OTTAWA, 1962

To our Readers

AS FALL is the season which normally marks the enrollment of students in the many educational and trades courses, this issue highlights the programs which enable Canadians of various ages and interests to play their full part in the growth of Canada. A growing economy and, particularly, increased automation have brought about changes in the Canadian scene. Everywhere is evidence of a rising interest in the education and training of the youth of our land.

New schools are being opened or planned to meet the growing demands for skilled manpower. Only about 30 per cent of employment in Canada today is in semi-skilled or unskilled categories and there are indications that these kinds of jobs may diminish further in relative importance as technology advances. The fastest growing occupations are those which require high levels of education and training. With the lessening of the physical demands of many of these jobs there are increasing opportunities for individuals with some physical limitations but who are able and willing to prepare themselves for occupations requiring skill rather than physical strength. Available reports regarding disabled individuals who have been successful in re-establishing themselves as members of the labour force indicate the importance of adequate academic and vocational training.

The need for adequate training programs and facilities was clearly recognized with the passing of the new Canadian Technical and Vocational Training Assistance Act outlined briefly in a previous issue of this bulletin. A multi-million dollar federal-provincial program to build new technical and vocational schools, to train teachers and to expand present training facilities has been underway in Canada since April 1961. This is linked directly to nation-wide efforts to meet Canadian manpower requirements by increasing the level of education and training of Canada's labour force, both present and future. More than 127,000 additional student places are being provided.

This expansion of technical and vocational training facilities and programs will offer Canadian youth and adults, able-bodied or disabled, increased opportunities to prepare for the jobs which are opening up in this age of technological change and will enable them to keep abreast with the increasing complexities of industrial occupations.

In this issue we bring you an article describing the new Canadian Technical and Vocational Training Program; reports of developments under this program, and accounts of how disabled individuals are benefitting from the imagination and ingenuity that has been exercised to see that such persons reach their goal of economic independence and productivity. We hope it may set you thinking about your own area and what action can be taken to assure that no individual in your locality, be he youth or adult, male or female, able-bodied or disabled, is denied the opportunity to get the training he needs so that he can develop to his fullest potential and render his best service to his community.

INCREASING TRAINING OPPORTUNITIES

By

C. R. Ford, Director,
Technical and Vocational Training Branch,
Department of Labour.

The purpose of the Canadian Technical and Vocational Training Program is to promote training to prepare individuals for entry into successful employment and to provide upgrading and retraining for employed persons. On this basis any training preparing an individual for a job can come under the program.

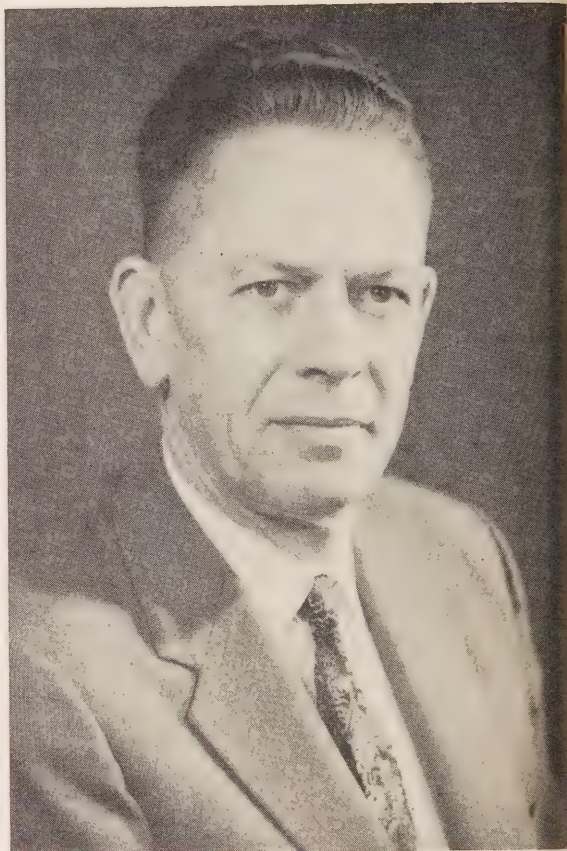
Level of Courses Offered

Courses offered in technical and vocational schools are at three broad levels:

- The secondary school level, for persons who have completed elementary school and are continuing in the school system. In these programs at least one half of the students' school time is devoted to technical, vocational or commercial courses designed to prepare students for entry into employment or to a post-secondary Institute of Technology. These are usually offered in technical and vocational high schools or composite high schools.
- The post-secondary school or institute of technology level, for persons who have graduated from secondary school or have an equivalent qualification in mathematics, science and other subjects.
- The trade or occupational training level, for persons who have left the regular school system.

Eight Broad Programs Offered

Vocational High School Training Program—This program covers those courses given as an integral part of high school education, in which at least one-half of the school time is devoted to technical, commercial and other vocational subjects or courses designed to prepare students for entry into employment by developing occupational qualifications.



Mr. C. R. Ford, Director of Technical and Vocational Training for the Federal Government has had long experience in the field of vocational training. After some years in industry, Mr. Ford turned to teaching and following graduation from Teachers' College in Calgary he spent 14 years as principal of a school in Alberta. He obtained his Bachelor of Science Degree from Bradley University in Peoria, Ill. and his Master of Science from the University of Minnesota where he majored in Vocational Education. He was for a time an instructor in a machine shop in Edmonton Technical School and spent six years as superintendent of a school division in Alberta.

He came to Ottawa in 1948 as Supervisor of Technical Education for the Canadian Vocational Training Branch of the Federal Department of Labour, later becoming Assistant Director. In May 1958 he was appointed to his present post.

Mr. Ford is familiar with all types of vocational training for all individuals, at all levels and in all schools across Canada.

Technical Training Program—This program will provide training at the post-high school level to an agreed standard of qualification in the principles of science or technology or other fields with the emphasis on the application thereof, except where such training is designed for university credit.

Trade and Other Occupational Training Program—This program will provide pre-employment training, upgrading or retraining for persons over the compulsory school attendance age who have left elementary or secondary school, and who require such training to develop or increase occupational competence or skills.

Training Program in Co-operation with Industry—A program to provide training, in co-operation with industry, for supervisors, and upgrading or retraining for other persons employed in industry.

Program for the Training of the Unemployed—A program for training or retraining of unemployed persons to improve employment opportunities and increase trade and occupational competence.

Program for the Training of the Disabled—A program for the technical vocational training and retraining of any disabled person who, because of a continuing disability, requires training to fit him for employment in a suitable occupation.

Program for the Training of Technical and Vocational Teachers—A program to provide training for occupationally competent persons in the art or science of teaching, supervising or in the administration of technical or vocational training programs at all levels whether in industry, in vocational schools or in institutes of technology.

Technical and Vocational Correspondence Courses—To provide instruction in the theory and practice of many occupations by self-study or correspondence.

Progress in Developing Programs and Facilities

An indication of present developments is that by next Spring there will be five new institutes of technology, 33 new trade schools, seven combined institutes and trade schools, and 177 new vocational high schools. Last winter vocational schools offered 100 different areas of occupational training.

One of the interesting developments taking place is the establishment of courses called "Basic Training for Skill Development". These courses offer a program for the upgrading of general back-

ground in mathematics, science and language. This program, although relatively new, is very effective. One province reports that 50 percent of the people who took this upgrading program last year entered occupational training courses for which they were not previously eligible because they lacked sufficient background to cope with the training. There was also a large percentage of these people who secured employment because they had upgraded their educational standing.

Training the Disabled

(Program 6)—Training of the disabled offers training to handicapped individuals who require further preparation before they can be accepted in the competitive labour market. This training is generally offered as part of the vocational rehabilitation of the individual. It may be given in full-time or part-time classes in: (a) the regular municipal or provincial vocational schools or institutes of technology; (b) private trade schools or business colleges approved by the province; (c) special training centres established or approved by the province; (d) universities; (e) in business or in industry.

Specialized training techniques may be employed where required because of disability, e.g., individual tutoring, home instruction, correspondence courses, etc.

Training on the Job

When suitable training is not available in institutions or other training facilities, training on the job can be arranged. In such cases a form of agreement with the employer is used setting forth the nature of the occupation to be learned, the length of the probationary period, the approximate length of training and finally a schedule of wage payments on a sliding scale with the employer paying an increased percentage of the wage payments over the total training period.

Living Allowances Provided

Training opportunities and facilities, however, are not enough to enable a person to take necessary training. He must find it possible to support himself, and sometimes his dependents, while he is undertaking his program. This is particularly true of physically handicapped persons. Therefore, provision is made for the payment of living

allowances in most of the provinces to enable a person to take advantage of the opportunities available.

In this dynamic age of technological change and industrial adjustment, our economy depends to a large extent on the competence of the labour force, and the occupational security of Canadians within this labour force requires higher levels of skills and knowledge than ever before. Vocational and technical education, therefore, is becoming more and more important as a factor in our economy.

Information regarding details of provincial programs in vocational or apprenticeship training may be obtained from the appropriate provincial official in the following list:

Vocational Education

Mr. J. S. White,
Director of Technical and Vocational Education,
Department of Education,
VICTORIA, B.C.

Mr. Jack Mitchell,
Director of Vocational Education,
Department of Education,
727 Administration Building,
10820—98th Avenue,
EDMONTON, Alberta.

Mr. J. A. Doyle,
Director of Vocational Education,
Department of Education,
REGINA, Sask.

Mr. B. F. Addy,
Director of Vocational Education,
Department of Education,
141 Legislative Building,
WINNIPEG 1, Manitoba.

Dr. S. D. Rendall,
Superintendent of Secondary Education,
Department of Education,
TORONTO 2, Ontario.

Mr. P. A. Fournier,
Administrative Secretary
Vocational Training Agreement,
Office of Administration of Agreement,
100 Place d'Youville,
QUEBEC 4, Que.

Mr. Jean Delorme,
Director General of Studies,
Department of Youth,
9175 St. Hubert St.,
MONTREAL 11, Que.

Mr. J. W. McNutt,
Director of Vocational Education,
Department of Education,
Box 866,
FREDERICTON, N.B.

Mr. W. D. Mills,
Director of Vocational Education,
Department of Education,
HALIFAX, N.S.

Mr. W. F. McMurtry,
Director of Vocational Education,
Department of Education,
CHARLOTTETOWN, P. E. I.

Mr. Frank Templeman,
Director of Vocational Education,
Department of Education,
ST. JOHN'S, Newfoundland.

Apprenticeship Training

Mr. Gordon Rodgers,
Director of Apprenticeship,
Department of Labour,
ST. JOHN'S, Newfoundland.

Mr. W. S. McMurtry,
Director of Apprenticeship,
Department of Education,
CHARLOTTETOWN, P.E.I.

Mr. R. S. Cochran,
Director of Apprenticeship,
Department of Labour,
Provincial Building,
HALIFAX, N.S.

Mr. B. W. Kelly,
Director of Apprenticeship,
Department of Labour,
P.O. Box 906,
FREDERICTON, N.B.

Mr. Remi Lair,
Director of Apprenticeship,
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"REHABSMANSHIP"

By PAUL CHRISTIE, M.D., C.M.

SOME YEARS AGO—several, to be exact—an attempt was made to apply the methods of one S. Potter to the field of medical education¹. The result was scarcely impressive, though Potter in his third monograph² showed, some of us thought, uncalled-for ruthlessness in the skilful counter-ploy with which he dismissed the work as "perhaps too advanced for the lay reader". Well—time's attrition has jaded our interest in these ancient jousts; but one may yet borrow from the Founder's methods.

How applicable they are to the faddy current realm of rehabilitation. Sincere young physicians, therapists, nurses, social workers—nay, even the humblest research psychologists—role-play innocently in hospital or clinic, serene in assurance of established places in the Therapeutic Team. Patients come and go, meekly tranquilized or operatively conditioned. Conferences drone peacefully towards their habitual inconclusion. What happens? Abruptly, a staff member finds himself appointed to a Board or Committee (frequently, and so somehow more formidably, *regional*) charged with instituting, even coordinating, Rehabilitation. (It is best always to use the capital R.) His role is shattered, his concepts confused—his self-image, perhaps, *threatened*. How to help him?

Testing the Limits

The now barely respectable field of Ink-Blot-manship rather unexpectedly supplies a potent device at the outset. After all we must—must we not?—define our terms. A Committee on Rehabilitation can almost always be led to attack this with relish. In order to make "a proper start", a representative of the Cosmic Consciousness wing can be looked to for an impassioned plea for womb-to-tomb inclusiveness. ("How can we help our professions begin thinking about Re-

habilitation *before* People become Patients?") Here, in the respectful hush which follows, it is well to remark—preferably in a pinched, reedy voice—"Nothing is to be gained by fostering semantic confusion. We'd better at least try to be a little precise—otherwise we'll just be laughed at."

Alternatively, an unwary colleague may choose to develop a finely articulated contrast between Treatment and Rehabilitation. The "After all . . ." rejoinder along humanist lines then becomes agreeably apt. Ask, "But where does the *patient* see this as happening? What really counts, after all,—I know we agree—is what we know of and do for him all *along the line*." Here, of course, the great gambit of Continuity-of-Caremanship may be effectively introduced.

In a particularly ruminative group, it may be found better to stress distinctions. One of our part-time observers reports a meeting which, by astute use of techniques of symbolic logic (with diagrams), was embroiled for an entire afternoon in an abortive brawl over whether Treatment includes Rehabilitation, or vice versa.

Structuring

This is still a decidedly O.K.—word. (How shabbily we ignore our debts to the sociologists!) It is of broadest significance to the young Rehabsman, and should frequently pass his lips and dignify his reports. Its meaning? To quote directly: "In structuring rehabilitation services, maximum flexibility of roles and provision for freely informal inter-communication must be ensured." (This almost meaningless statement was awarded high honours at a recent Jargon Exhibit.) Similar sonorities can readily be devised to span many an unplumbed chasm of uncertainty in the hazardous territory of organization planning. The tyro may understandably wonder whether such jargonship might not even influence the actual course of events. His concern, however, is groundless. The service machinery will creak along by fits and starts determined, as always, by

¹ Christie, P. "Wardsmanship, or the Management of the Intractable Clinician". McGill Med. J., XX-2, p. 131, April 1951.

² Potter, S. "One-Upmanship", etc. London, Rupert Hart-Davis, 1952, p. 26.

the interactions of the more or less prickly personalities involved. Our beginner must remain alert for chances to point this out, bitingly.

Integration Play

These high-order abstractions are heady stuff. Many a committee has blithely confined itself to such discussions for months or longer. At some stage, though, there might admittedly arise a sense of obligation to deal with some actual cases. (It is not a bad ploy to propose this, with restrained Plansmanship, quite early, especially if the problem. Chairman seems to be getting too smug.) Here, the young Rehabsman too often feels clammy ill at ease. How needless this is. Devoutly subvocalizing "Nihil humanum . . .", he should press forward, confident in the awareness that a vast assortment of up-to-date gambits is available to him. Consider, for example, the ultra-contemporary movement to return mental health care to medicine, the community, etc. (Formerly known elsewhere in the literature as "Togetherness"). Capitalizing on this from the start—it is not necessary to inquire whether medicine, the community, etc., want us back—the Rehabsman, in his contacts with both patients and other agencies, will take pains to establish a (wholly specious) Climate of Belonging. The resulting aura of matey folksiness which will surround the agency or committee will serve admirably to conceal staff members' continuing sense of mingled rejection and superiority.

Continuity of Care was already mentioned. In the hands of our master Rehabsmen, no more pulverizing ploy has yet been developed for use in discussion. But its use in practice is fraught with peril, because it is so readily adapted to counter-gambiting. Once a problem case has been referred, the maxim of continuity will be widely quoted to ensure that the community is rid of it for good. When several agencies are involved, much conference time can be spent tracing the appropriate lines of continuity. Rehabsman should learn how to beam at an inexperienced and hostile caseworker, aghast at the thought of endless repetitions of the intake interview she has just described, and say winningly: "This beginning positive identification of the client with you is much the most healthy and constructive factor in the whole picture. I'm sure our planning should

rest on this. Other resources, of course, can be called upon as needed . . .".

Enthusiasm must be tempered by awareness of possible conflict of ploys. Emulation and praise of general hospitals are in vogue, and are frequently to be employed in raising the choler of the older generation of mental health personnel. Equally, the vital role of the general practitioner in Rehabilitation is a point to be stressed—particularly in those circles interested in medical economics. To combine these manoeuvres, however, may well prove unduly sadistic in the presence of an actual G.P., who is quite likely to have received no fees from his last five psychiatric referrals, and simultaneously to be freshly smarting from the rebuff of his latest attempt to secure additional admitting privileges in his local hospital.

Patients' Needsmanship

Current interest in vocational and avocational aspects opens up "The World of Work" and creates a diathesis replete with engaging ploys. Top rank for versatility and bland impudence in their use must, I suppose, be awarded to the noted clinician O'Flaherty. Confronted in Disposal Conference with a schizophrenic still glassily apathetic or buzzing with residual delusions, or with a sexual neurotic almost frantically preoccupied with his fetish, O'Flaherty nods calmly. In summary, after the patient's departure, he makes little or no reference to symptoms, stressing instead the lacunae in the patient's learned endowment—his lack of shared interests and prestige—his consequent frustration and dissatisfaction in a highly technological culture. For the patient known to have failed wholeheartedly in every didactic situation since kindergarten, O'Flaherty recommends a trade of some sort. "Could we obtain funds to pay his room and board while he attends the technical school next fall?" (This technique, of course, is a close cousin to the widely guilt-provoking stereotypes of Community Tolerance and Acceptance of Limited Goals.)

Special Gambits

It is believed that each member of the Rehabilitation Team can evolve ways of adapting these methods to his particular purpose. However, the possibilities of other uniquely derived

[Continued on Page 11]

VOCATIONAL TRAINING AND VOCATIONAL REHABILITATION

by W. Darrell Mills

Director of Vocational Education
Province of Nova Scotia

Any valid assessment of the importance of A as an aid to B must be based on the nature of and relationship between A and B. In this paper A is vocational training and B is vocational rehabilitation of disabled persons.

In the broad sense, vocational training is an organized part of the process of developing manpower in relation to social and economic requirements as determined from time to time by public and private institutions. In the narrower sense, by commonly accepted definition both in legislation and practice, vocational training is any course of instruction which prepares a person for gainful employment in an occupation or increases a person's proficiency in an occupation. In vocational training, a trainee is involved with instruction for ultimate employment in an occupation.

Administrators of any program of vocational training must ascertain from the employment world

- i) the occupations for which courses of instruction are needed,
- ii) the instruction (content) needed in such occupations, and
- iii) the number of trained persons needed in each such occupation.

On the basis of such requirements, the administrator sets about his task of producing adequately trained persons for the required occupations in the required numbers, but it is to be noted that these requirements have their origin outside vocational training as such.

Just how the administrator sets about his task varies, of course, with the administrator, his principals and his adopted principles. Generally speaking, however, he wishes very much to have three conditions operative:

First, that the trainee should have a reasonably valid occupational goal—an occupation chosen by the trainee with professional counselling and



W. Darrell Mills was educated in Nova Scotia and attended Acadia University, graduating with a Bachelor of Science degree.

Except for six years of army service he has been continuously engaged in the field of education. During 10 years of teaching before the war he developed a deep interest in the problem of school drop-outs and the place of training and retraining in the development of the manpower resources of our country.

Following demobilization in 1946, he became supervisor of Vocational Correspondence Courses for the Province, later assuming the post of Assistant Director and then Associate Director of Vocational Education. In 1959 he assumed his duties as Director, succeeding Mr. E. K. Ford.

Last May, Mr. Mills, along with five other Canadians interested in vocational training visited several European countries including Great Britain, Sweden and Holland observing (technical) vocational training institutions and studying their programs for the training and development of their work force.

valid for his schooling, abilities, and interests and for the occupation chosen;

Second, that the trainee may train in conditions which resemble as closely as practicable the conditions that exist in the occupation of his choice; and

Third, that the trainee should train with reasonably certain expectation of employment in the occupation of his choice, immediately at the conclusion of training.

Referring to the second condition set forth above, public vocational training in Nova Scotia attempts to provide training conditions to re-

semble employment conditions as closely as practicable by having each vocational course (i) specific to an occupation and based on an analysis of that occupation, (ii) taught by an instructor selected from among recognized masters of that occupation with vocational teacher training superimposed on occupational competence, and (iii) operated in training areas equipped and laid out as is found generally in that occupation.

Vocational Rehabilitation of Disabled Persons (I use the qualification "of Disabled Persons" in recognition of other areas of vocational rehabilitation such as unemployed, war veterans, etc.) can be regarded as a part of the program of manpower development—that part which is concerned with the remaining manpower of persons who by accident, either biological or physical, are less than they would have been without the results of the accident. Manpower generally is developed by a process in which is included schooling, counseling (both educational and vocational), maintenance of health, social services, placement in employment and, in most cases, organized vocational training. Vocational Rehabilitation of Disabled Persons is accomplished by almost the same process, differing only in the relative amounts of and sequence of the sub-processes.

Vocational Rehabilitation of Disabled Persons is by definition accepted in legislation and in practice as the process of preparing a disabled person for gainful employment in a self- or partial-supporting capacity. This definition resembles the definition of vocational training given above, but there is one very significant difference—vocational training is concerned with the narrower preparation by a "course of instruction" while vocational rehabilitation of disabled persons is concerned with a broader preparation by a range of activities which may or may not include a "course of instruction".

Vocational training and vocational rehabilitation of disabled persons have at least one operational similarity—they both are principally concerned with individual cases and the importance of each to the individual can be in direct proportion to the assessed needs of the individual. It becomes obvious from what has been said above that the importance of vocational training as an aid to vocational rehabilitation of disabled persons is in direct proportion to the effectiveness with

which it can contribute to the assessed vocational training needs of each disabled person.

These needs vary with the individual as well as the disablement, but in many ways the gamut of needs of the "disabled" resembles the gamut of needs of the "able". It becomes difficult to distinguish between the vocational training needs of the low ability "able" and the low ability "disabled" in regard both to vocational training, if any, and to placement.

Perhaps the same significant conclusions regarding the importance of vocational training as an aid to the vocational rehabilitation of disabled persons can best be drawn from practices and experience in Nova Scotia.

In operating our program of training disabled persons we

1. appointed a supervisor whose sole responsibility was to initiate and operate a program of vocational training of disabled persons within the program of the vocational rehabilitation of disabled persons;
2. followed by and large the same principles and practices used in training persons generally and as set forth above;
3. have trained approximately 360, beginning with 28 in 1955 and increasing to 110 in 1962;
4. have had approximately 92% placement with nearly all being placed in occupations for which they were trained;
5. have had a steady decline in drop-outs;
6. have trained persons whose remaining abilities for the most part were such that they could compete for placement with "able" persons.

Our conclusions, based on the operation and results of our program of vocational training for disabled persons, thus far are

- (1) that our essential principles and practices in regard to establishing and operating vocational courses are sound and apply equally to vocational training in general and vocational training of the disabled;
- (2) that there is no essential difference between the problem of training a disabled person and the problem of training person generally;

- (3) that a professional counsellor, at the time of counselling a rehabilitant, must have
 - (a) an accurate knowledge of the remaining abilities of the rehabilitant, and
 - (b) an accurate knowledge of the conditions that prevail in the occupations being considered by the rehabilitant;
- (4) that the disabled person should be trained in the same classes as others are trained, when they have chosen an occupation for which others are training, i.e. there should not be separate classes for disabled people in all cases;
- (5) that training disabled persons presents at least two additional operational requirements
 - (a) a person to whom disabled trainees can turn for advice and encouragement (in Nova Scotia's case, this has been the Supervisor of Disabled Persons Training) and
 - (b) instructors who will exercise (i) the extra patience and effort when re-

quired by the disablement or its effects and (ii) vigilance for adverse effects of training conditions (hence likely employment conditions also) on disabled trainee;

- (6) that the primary purpose of a vocational course is to provide a person with the occupational skills, knowledge, and attitudes necessary for successful employment and that any therapeutic benefit that the course might provide for the disabled in training should be regarded as welcome but secondary.

From the foregoing, it must be concluded that the importance of vocational training as an aid to the vocational rehabilitation of disabled persons is the same as the importance of vocational rehabilitation itself; it is so important that it behooves both those in vocational training and those in vocational rehabilitation to understand and complement each other's function to the ultimate best interests of disabled persons and manpower development.

[Continued from Page 8]

plays should not be neglected. The Multidisciplinary Approach must be fully exploited (and frequently mentioned). For illustration may be outlined:

Right to Privacy Play. At an early stage in most discussions of Rehabilitation, there will be mention of the desirability of a central information pool concerning cases in the area. The proposer innocently conceived his idea as a help in coordination. Any social worker present should, however, (a) deliver a passionate diatribe based on recollections of the Social Service Index, or better, (b) point out with gentle urgency that, "The different problems can be worked through if people will only realize how important it is to *share* . . . We don't want a lot of red tape and formality . . . All the contacts are helping ones, surely." (Potter might, for once in a way, be quoted directly here: "Students must not be confused if, after reading this paragraph, they are left with a feeling that they are not quite certain which side they are meant to be on. If we are continually expected to take sides, that is

the end of the argument." One-Upmanship, p. 68 fn.)

The Accent on Scientific Rigour. Clinical psychologists will find it vital to practice, preferably in front of a two-way mirror with a tutor observing them for guidance, a range of facial expressions indicative of politely restrained nausea, for use when Aptitude Testing is mentioned. (This should not be attempted before the M.A. level, however.)

New times, new ways. Surely enough has been said to demonstrate that the increasing diversity of demands in this splendid new field should offer no reason for discouragement or apprehension. In Rehabilitation Services, as ever in older, less co-ordinated settings, young practitioners in every area can feel confident, with help, of achieving their Significant Social Role.

Dr. Christie, former Assistant Superintendent of the Ontario Hospital, Kingston, was recently appointed Superintendent of the Ontario Hospital, Toronto. In the delightful style of Stephen Potter he pokes fun at some sacred cows quite familiar, no doubt, to most of our readers, Dr. Christie has kindly consented to the reproduction of his article which originally appeared in the September issue of "Canada's Mental Health".

TRAINING

What it Means to Blind Canadians

A national community agency that enables the people it serves to earn more than it receives from donations and grants is the Canadian National Institute for the Blind.

In 1962, the CNIB received \$2,572,646 from grants, bequests and donations. In the same year blind persons earned \$3,467,092. This means that the blind of Canada earn nearly \$900,000 more than the total of all CNIB donations and grants. This unusual achievement came about through the CNIB employment service, which, in turn, reflected intensive training through the National Vocational Training Program.

Services Provided by C.N.I.B.

In the same year CNIB operated 20 residence and general service centres for more than 900 blind people, served 24,000 blind persons through 50 offices, provided home teaching and administered a library of 100,000 book records and 20,000 Braille volumes.

Today, blind people are accepted in a wide variety of jobs from the executive desk to the janitor. Yet of the 24,000 eligible for CNIB service, only 2,000 hold full-time posts. A look at the age break-down of Canada's blind population soon shows why. Forty-six per cent are over 65 when they lose their sight; 1,800 are children under 20 still going to school. Another 7,500 are married women, the majority housewives. Eliminating these groups and allowing for other disabilities among those of an employable age, it is easy to understand why only 2,000 blind persons work full time. Among these 2,000 are people in all walks of life whose employment needs are met through Vocational Training and CNIB Placement Service.

Employment in Industry

In industry, the blind employment officers survey plants, convince company management of the capabilities of a blind worker, train the man on the job and call back frequently to check on his progress. A recent placement in Winnipeg illustrates how training can enable a blind person



Trained and placed by a blind employment officer of the C.N.I.B. Walter Else, St. Thomas, Ont., assembles hose and pipe connections for automobiles at the rate of 600 units an hour.

to share in the production of kitchen furniture. Before the CNIB survey, the metal polishing in this plant was done by the sighted, and was considered a sighted man's post. Then the CNIB employment officer convinced management that they should give a blind person a chance on the polishing bench.

At the beginning, the new blind employee had to learn the art of metal polishing, to produce a uniform finish without seeing it and to avoid accidents with the polishing wheels. He developed a sense of timing to produce the proper finish on the many sizes and shapes of tubing that came along the assembly line. With the buffing wheel turning at 2,000 RPM he had to exercise great caution to prevent the tubes from spinning back at him. By holding the tube at a certain height on the downward side of the buffing wheel, he was

able to control the action of the metal. By wearing gloves he was able to avoid burns. After three months, his training period was over. He was producing 75 per cent of the required quota. After six months he was up to top production.

Opportunities for Blind Women

In recent years young blind women have found a new career open to them. Special courses for young women are leading blind dictaphone typists to office positions with large firms. After 10 months' instruction and study, also made possible by N.V.T., they graduate with a typing speed of 50 words a minute and a basic knowledge of accurate spelling. Just last summer three new typists achieved outstanding honours in their dictaphone training. Reporting to the Ontario Division Annual Meeting of the CNIB, Division Chairman Norman W. Long said: "I am proud to tell you of the achievements of three Ontario girls in the dictaphone typing section of the vocational training course. They graduated with proficiency in spelling and the highest average typing speed ever recorded in CNIB's 10 dictaphone courses. One had an accurate speed of 73 words a minute while the other two attained 63 words a minute. They won certificates from the Dictaphone Corporation, New York, and all three have been placed in excellent positions in the business world."

The telephone switchboard, too, with a touch-type board and training for the blind operator has recently opened an additional avenue of employment for competent blind girls. Today, many careers are open to the blind.

The Field Secretary

Some take positions on the CNIB professional staff. In this field several months' intensive training and work experience is necessary. These courses are on a nine-to-five basis, five days a week and require considerable after-hours' study and written examinations. Perhaps the most important of these graduates are those who become field secretaries. These men are carefully chosen for their ability and background before they are assigned to the training course. On completion of their training they are placed in one of the CNIB's 50 locations. While these representatives have their offices in the large cities in the land, their work takes them far out into the surrounding

counties and districts. Much of the progress in the work of the CNIB is due to the energetic efforts of these sightless field men.

Their first task is to contact the blind people in the district assigned to them and learn their condition, needs and abilities. When the CNIB field secretary calls for the first time on a newly blind person, his own sightlessness and capabilities make an immediate and lasting impression. The new client cannot say: "Why don't you practise what you preach?" as he might if the officer were sighted. His very presence, the fact that he controls an office, even his ability to light a cigarette, all give encouragement and restore confidence.

The field man is, in a sense, a contact man for all the other departments of the CNIB. With his first call he begins assessing the blind person. He is familiar with the many services of the Institute and while he talks he is asking himself which departments can serve this man best. The field man is also responsible for the raising of funds and the public relations program in his area.

The Home Teacher

Another important staff member to take vocational training is the home teacher. The teachers, who are also blind, hold the key to the rehabilitation of the newly blind. They train the newly blind in Braille reading and writing, and give instructions in all types of handicrafts, such as knitting, mat making and leather work. Besides providing hobbies and often a supplementary income, these crafts are a psychological aid to the newly blinded person in making his adjustment. The example of the blind teacher is a confidence-builder during this transitional period.

Sometimes it is a long fight back from the edge of despondency. Often the first few visits of the teacher are spent in helping the relatives to understand their part, and in proving to the pupil what she or he can achieve. In the early stages the home teacher assists her new pupil to shift from a vision-centred world to a life of sound and touch. It is not easy. The change requires considerable adjustment on the part of the blind person and his family. Pre-vocational training, known as adjustment training, is a great aid to the blind in conquering their handicap. A course of several months has been devised to assist the newly blind Canadian with this pre-vocational adjustment.

[Continued on Page 15]

COLLEGE LIFE FROM A SIT DOWN POINT OF VIEW

Miss Joanne MacArthur has been a paraplegic since she was injured in a car accident in 1954. She returned to high school, graduating in 1957 and winning the Memorial Scholarship. She continued her studies at the University of New Brunswick, graduating in June, 1961. Miss MacArthur has written a number of articles for *Caliper*, the magazine of the Canadian Paraplegic Association. One of these written during her time at University is reproduced here.

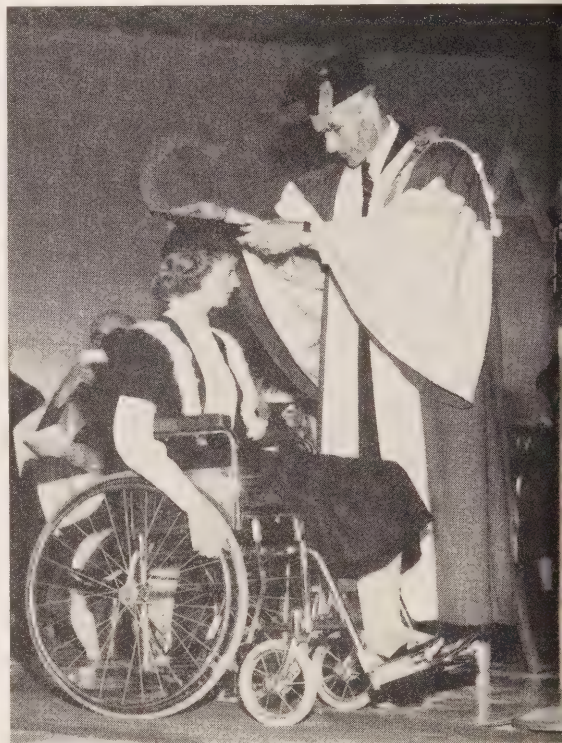
By JOANNE E. MACARTHUR

In ages past it was permissible for anyone in a wheel chair to use this as an excuse for remaining at home, sheltered from the outside world. Now, people in wheel chairs carry on in the same way as those old-fashioned folk who use their feet for transportation. All across Canada the wheels are turning.

"Find a wheel and it goes round and round." I am a freshman at the University of New Brunswick and find that the wheels have little time to stand still.

U.N.B. is built on a hill. The only reason I can see for this was so they could call the year book "Up the Hill"! Every building on the campus has a set of steps so steep that even a mountain goat would think twice before attempting them. In one building there is an elevator—a freight elevator. The second day at college, they gave me a key and the honor of being the only student allowed to use it. Did I hear someone say they don't lock elevators? Well, they do this one, and no wonder, for in it are stored various treasures—a year's supply of toilet tissue and soap for wash rooms, also a large amount of cleaning powder, a huge stack of cleaning rags, the mops, brooms, and last but not least, the scrub pail. I am the only student who goes from first to second floor sitting on top of the scrub pail holding a drippy mop in my hand. The elevator has another feature—it is very old and often gets tired half way between floors. What better excuse for missing half an hour of a lecture than being stuck between floors in the elevator?

It is a theory today not to believe anything you are told but to try it and prove for yourself. For this reason I get my arms pulled off a dozen



Miss Joanne MacArthur receives her degree from President Colin MacKay at the University of New Brunswick.

times each day; but let me explain—my chair has detachable arms. Whenever anyone goes to pick it up, they always take it by the arms. I tell them the arms will come off but they look at me as if I had holes in my head and keep right on. When the arms do come off, they think they have done something terrible so they throw the arms and run; I am left sitting without any arms.

I am the first co-ed ever to get stuck in the doorway of the dressing room. The door is rather narrow. One day I was going through it in

a hurry and hit the door casing (door casings are forever jumping out in front of me!) After hitting the side I bounced back and got crosswise in the door. There I was, stuck solid until some gallant soul came to my rescue.

I have found there are ways of taking a chair down stairs that I didn't know existed. One way I will not recommend even though it is much the fastest. If the chair is tipped up on the front wheels instead of the back ones, the occupant (that's me) will fall out head first, leaving the empty chair which is much easier to bring down. I have only tried this once; that time I escaped with a skinned knee. The crack in the floor where I landed still remains a mystery to all but a few.

After I finish college I think I will go in the taxi business. At the rate of four trips a day, after four years I should own the taxi company I travel with. If anyone wants a job driving a cab, please get in touch with me. I may drive a bulldozer, for driving a wheel chair through a corridor packed with a few hundred people is much the same thing. I am not a hit-and-run driver, I really feel badly when I see someone sprawling on the floor. It is simply a case of circumstances. When I come out of a class I have to go on to another class room and the only way to get through the crowd is to shut my eyes and go like hell!

I have always disliked Math., but this year I did find it very interesting. The Arts students have their Math. in a building apart from the other buildings, reached by a steep, narrow, and rocky path. This was a bit difficult for me, so the Professor said I could take my Math. with the engineers. I am the only girl in the class with 35 boys; things couldn't have worked out better if I had planned them myself!

I was a bit skeptical about entering U.N.B. When I looked around at all the buildings and steps I felt it would be impossible, but soon I saw how silly my fears were. The first few days two members of the Student's Representative Council met my car and saw to it that I reached my classes. After that, there was always someone around to help. I find that if I go to the top of the stairs and look helpless it is not long before someone offers to take me down. Even the professors are willing to assist and often lend a hand. The janitor is forever leaving his work to see that I get to the various classes on time. In a

college of over 1,450 students there is no lack of helpers.

All in all, college is quite an experience. The steps which I thought would be an impossibility are just a slight inconvenience.

[Continued from Page 13]

Today the newly blind client may move to a CNIB residence and service centre for a rehabilitation course. There he meets other blind persons at various stages of development. Some are in training like himself. Others are permanent residents. The newcomer learns handicrafts to sharpen his sense of touch and then Braille so that he may read and write. He learns to dial the telephone without reading the figures and to use a Braille watch.

Recreation Needs are Met

To speed the adjustment period and to provide an outlet for the social needs of the blind, CNIB conducts a Canada-wide recreation program. Blind people bowl, swim, dance, golf, play cards and take an active interest in hockey, football and the world series. In some provinces summer camps provide a holiday for active blind people. Sighted volunteers take an important part in the recreation program. They serve as coaches on the bowling alley and on the links. They share the swimming party or card game and find the project a teamwork venture where both blind and sighted give and take.

To the success of the recreation program stand 73 clubs of the blind across Canada with an active membership of 4,500 blind members. Beside them are some 7,000 sighted volunteers who act on CNIB boards, committees and women's auxiliaries, assisting in the day-to-day living of blind Canadians.

"The aim of the CNIB is the complete rehabilitation of the blind", says A. N. Magill, managing director. "All our services contribute to this purpose. Those who take vocational training enter employment and become self-sufficient, are the foundation of the entire fabric, and prove themselves to be leaders of the blind of Canada. At present 50 blind students are taking University courses and will shortly take their place in the world with professional status. The achievements of the blind have never been greater, and the keynote to their success is vocational training."

OLDER WORKERS—TRAINING AND EDUCATION

A summary of a recent broadcast on the Labour Department's weekly radio program, "Canada at Work", made by H. L. Douse, Chief, Division on Older Workers, Civilian Rehabilitation, Department of Labour, Ottawa.

A great deal is heard these days about the difficulties older persons encounter in attempting to secure employment. Much of this difficulty is attributed to discrimination arising from prejudice in favour of youth . . . on the part of employers and many of those concerned in hiring, promotions and retention in employment. There is a great deal of truth in this.

Accent on Youth

The 20th century accent on youth has given many people the idea that when a man or woman has passed the age of 40 he or she on is the down-grade mentally and physically . . . Enlightened people today know this is a false belief. People are usually just entering the most productive period of their lives at 40.

Age discrimination, however, can arise from other causes besides those stemming from prejudice. One of these causes is the fact that too many of the present generation of people past 40 lack the education and skills necessary to fill many of the jobs in modern industry.

No employer, no matter how much he may appreciate the qualities of maturity offered by middle-aged and older persons, can afford to hire a person who lacks the education or skills required for the job. It is, therefore, imperative that workers of all ages strive constantly to broaden their knowledge, education and skills. Learning should not stop when we leave school.

Abundant Opportunities for Improving Education

In Canada today, opportunities for Canadians to improve their knowledge and skills are greater than ever before. In most urban areas night classes are conducted in high schools, vocational and technical schools and in many of our universities. These courses cover a great variety of subjects. Correspondence courses are also available.

The Federal-Provincial Vocational and Technical Training Program provides courses of training for many occupations and most of the courses have no age limits for entry. In most provinces today upper age limits have been removed from entry to apprenticeship in many skilled trades.

In addition to a broadening of knowledge and education, specialized training is, of course, essential to meet the demands of many job openings. This may be secured through full-time, part-time or correspondence courses.

False Assumptions Regarding Learning

It is true that our culture has given rise to some incorrect assumptions about learning ability. We tend to associate learning with schools, universities and youth. Our modern society is inclined to divide people into age groups such as childhood, youth, adulthood, middle age and old age without reference to individual ambitions, needs and abilities. We sometimes forget that human beings are fundamentally the same regardless of age. Our hopes, aspirations, individual preferences and likes and dislikes together with our rights as citizens do not disappear with advancing years. Nor does ability to learn if we have a thirst for knowledge. Some people seem to think that learning ability belongs only to youth. This is a false assumption.

Education a Continuous Process

We all know people who many years ago left school at the Grade 9 or 10 level, but by application, study and self-education are today considered to be educated people. Some wise employers in interviewing middle-aged applicants for jobs recognize that the fact that the applicant may have completed only Grade 9 or 10 twenty-five years ago does not necessarily mean he is not qualified for a job requiring senior matriculation today. His experience, education and acquisition of knowledge since leaving school may well have raised his educational standards far beyond those of the average new matriculant.

Improvement of Knowledge and Skills Essential

The success of older workers in maintaining steady employment or securing new jobs if they should become unemployed, depends to a very large extent on whether they have improved their educational standards, developed new skills or

increased their former skills. The responsibility for doing this lies upon every individual. Facilities are available, but it is up to each and every one of us to make use of them.

It is important for the young worker, who today may be proud of his knowledge and skill in some particular trade or vocation, to think about the future. Fifteen or 20 years from now, when he becomes an older worker, his present occupation may have been rendered obsolete by the rapid advances of modern technology. He should, therefore, be preparing himself all through those years to step into other work if and when it becomes necessary.

Many employers today are taking steps to encourage their employees to take training to improve their qualifications so that they can become upgraded to more secure jobs. Some companies have their own training programs.

Traditional Training Methods not always Suitable for Older People

Research into methods of training is going on in many parts of the world. Many older persons have successfully completed courses which were basically designed for young people. However, experiments have shown that traditional methods of instruction are not always suitable for older persons. For example, courses which entail a great deal of memory work may be difficult for persons in their forties and fifties who are not accustomed to memorizing. This point can be quite significant when training of older persons for industrial tasks is undertaken.

U. K. Experiment

An interesting experiment was carried out in the United Kingdom which clearly indicates the advantages of eliminating as much memory work as possible. In this experiment 12 housewives between the ages of 30 and 50 were recruited for training in invisible mending in the textile industry. None had any previous experience in this line of work. They were divided into two groups of six and each group was trained by one of the following two methods: The first was the traditional "exposure" or "sit-by-me" method. This traditional method consisted of the trainee working alongside an experienced mender who described the weaves and demonstrated the methods of

mending them. Training periods under this system normally took anywhere from six months to two years.

New Method

The method for the second group was called the "experimental" method. In this method the trainees were given practice on a specially-woven large scale weave and were then told to copy it on a smaller frame using thick elastic instead of thread. In this way they saw the detail for themselves and were able to learn without any serious mistakes. They were gradually transferred to smaller weaves with the aid of industrial magnifiers. Thus at no time was the task too difficult for them.

Each group of six trainees was given 8 hours of instruction in mending three basic weaves and one smaller weave. This was followed by 12 hours of further practice. Two of the 8 hours of those taking the experimental method were spent with the special training devices.

The group trained by the traditional "exposure" method spent the whole 8 hours on actual production work. After two hours training in the "traditional" or "exposure" course one trainee resigned. She had been unable to do the work at all and had no confidence in being able to continue.

It was found that those in the "experimental" group were inclined to mend much more quickly than the trainees in the "exposure" group. This was especially noticeable in connection with one particular weave in which the slowest of the trainees in the "experimental" group took less time than the fastest of the trainees in the "exposure" group. Also, three of the "exposure" group mended one weave incorrectly, while only one of the "experimental" group was unable to complete this mend correctly.

Older Trainees Performance Remarkable

The performance of the older trainees was in many respects remarkable. For example, in the "experimental" group one woman aged 47 had reached "target time" on one weave after eight hours training. "Target times" were assessed by examining the performance of experienced menders in the trade. It was noticed that in a matter of hours the older people trained under the experimental method learned to mend at a rate

which it had taken younger people previously trained by the traditional method several weeks to attain.

The results of this experiment suggest that older people, if taught by an appropriate method, are able to accomplish a task much more easily than they would otherwise.

Memorizing Reduced to Minimum

In the experiment the need for conscious memorizing was reduced to a minimum and by so doing several of the difficulties common to many of the current methods of training were overcome. This experimental method insured that at all times the task to be performed—and to be learned while being performed—was never difficult enough to prevent understanding or accurate performance. Thus mistakes were prevented during early stages of training and did not have to be “unlearned” later which is a process comparatively difficult for older people. Another significant fact was that by performing accurately in the early stages the trainees were prevented from losing confidence in the job. Loss of confidence in the early stages of training can often prevent successful learning by older people.

Age in our Work Force

Let us look for a moment at Canada's work force. Our population has aged during the first half of this century. From 1901 to 1956 the average age of the population increased from age 27 to 31. While the rate of aging is now declining slightly owing to high birth rates and higher immigration since World War 2 the trend indicates that Canada's population will grow relatively older in the future. Even now more than one third of our labour force is aged 40 or over. Thanks to the advances of medical science more people today are living—and retaining their health—to more advanced ages. This means that more older people are physically capable and often desirous of working to later ages than was the case a few generations ago.

Fewer Workers in “In-Between” Age Group

Young people, too, are entering the labour market in increasing numbers because of high birth rates during the last 15 or 20 years. How-

ever, the “in-between” age group—those from 30 to 40—is likely to be proportionately smaller during the next few years because of the low birth rates of the depressed years of the thirties.

As the “in-between” age group becomes relatively smaller the younger and older age groups will each become proportionately larger. This trend means that employers will have to draw a substantial part of their future manpower requirements from both older workers and young workers as there will not be enough of the “in-between” workers to meet their requirements. This changing situation means that employment opportunities will be available to both young and older workers provided the applicants for the available openings have the qualifications needed. Available jobs will go to those who are prepared, to those who have the desire, initiative and will and are prepared to work at improving their educational standards and skills.

It cannot be over-emphasized that education, broadening of knowledge and improvement of skills is a process which should be extended throughout life and not cease when sufficient knowledge is acquired to perform one job.

The alternative to growth and gradual readjustment may be the eventual loss of a place in the competitive labour market. Opportunities are available and the vocational preparation should start now if future problems are to be overcome.

[Continued from Page 27]

In summary, three basic vocational components in rehabilitation services have been identified: (1) Pre-vocational counselling, assessment, work conditioning; (2) Training; and (3) Placement. It has been suggested that these components are inter-related parts of a continuing process and case material has been presented to illustrate the point. The role which on-the-job training opportunities can play in implementing rehabilitation goals has been discussed and the advantages of this type of training over conventional programs have been examined.

It is hoped that the presentation will encourage the wider use of pre-vocational evaluation and training-on-the-job techniques in rehabilitation services.

I Saw a School Come to Life

A summary of a recent broadcast on the Labour Department's weekly radio program "Canada at Work" made by Mervyn Kelly of the Information Branch of the Department of Labour.

A few weeks ago I attended the official opening of the New Brunswick Technical Institute in Moncton. This school is one of the many new technical and vocational schools recently completed or currently under construction in Canada.

This Institute teaches trade subjects such as barbering, electrical work, plumbing, carpentry and hairdressing, as well as the more advanced subjects at the technician level. Eventually the school will probably be used exclusively for the training of technicians.

It may be of interest to know what we mean by a technician. Usually a technician has completed two or three years of education beyond high school graduation. He is the link between the engineer or scientist and the skilled tradesman. An engineering technician is the person who makes the engineer's ideas work. He translates these ideas into new products or processes. A few days before leaving Ottawa for Moncton, I sat at my desk looking at an architect's sketch of the New Brunswick Technical Institute. It looked just like any other building. It was the kind of structure that you might see being built in almost any community in Canada. There was nothing elaborate about it, nothing spectacular, just a plain ordinary building. But this was more than just an ordinary building. It was a place where young people and adults acquired technical skills and knowledge to fit them for the world of work. From this building would come to-morrow's leaders of industry. From here would graduate the skilled people who would make it possible for electric power to continually flow into your home—who would keep radio and television stations on the air—and who would build new buildings and provide a hundred and one services to the communities of New Brunswick and perhaps even to the rest of Canada.

The New Brunswick Technical Institute will accommodate 600 students. In this institution young people will be able to learn the building trades, motor vehicle repair work, commercial occupations, service occupations (such as hair-

dress, barbering), machine shop trades, welding, radio and television servicing, engineer's assistants and architectural draughting to mention just a few.

I found this school a place of industry. It was almost as if one had taken a number of small businesses and companies and put them under one roof. Walking into the building trades section of the institute I saw a house being constructed right from the basement up. The students here were carrying out the tasks you would see going on in almost any new housing sub-division in Canada. The student electricians were wiring the house, the carpenters were constructing the walls and putting on the roof, the plumbers were putting in the water system, while oil burner mechanics were installing the furnace. The bricklayers were busy finishing the outside of the house and a multitude of other activities were taking place in this unique classroom. When the house was completed it would be torn down and a new class would start to build it all over again.

As I walked through the school I noticed that some of the rooms were unfinished. There were no partitions. There was no wiring or lighting and none of the conveniences of the ordinary classrooms in the institute were in evidence. The Director of the Institute, Mr. C. L. Dow explained that these rooms were left unfinished on purpose and that the student carpenters, electricians, plumbers and bricklayers finished the rooms as part of their course.

There was one of the most modern automotive shops that I had ever seen. I dare say the students were using the most up-to-date equipment available in the automotive industry. In large rooms, laid out much like any modern garage service centre, young mechanics repaired engines, crumpled fenders, faulty transmissions and worked on almost every problem they might meet when they went out into industry.

I saw welding shops, electronic laboratories, machine shops, radio and television repair shops, metal testing labs., a large barbering classroom,

a hairdressing classroom, dressmaking classroom, a large kitchen and dining room and a miniature hospital ward. In this latter classroom, students were learning to be nurses' aides and sometimes their "victims" were fellow students who had been injured in the machine shops or in the automotive repair shops.

In the Institute's dining room I saw student waitresses practicing their skills on the faculty and fellow students. I have never seen service like that given in the institute in any dining room that I have ever been in. The tables were set to perfection. Everything was served just so, and the food was excellent. It is prepared by student cooks and sold to the faculty and student body.

I also saw the technicians at work designing complicated electrical circuits and carrying out tests on electronic apparatus. I saw them building special test equipment and working in the draughting rooms, preparing for the day they will move into industry. I had a difficult time tearing myself away from these special classrooms.

In a way this Institute is very different from other schools but in another way you are still very aware of the traditional classrooms and the traditional school-like appearance and atmosphere.

This Institute, however, has an excitement about it. You find yourself fascinated by machines you have never seen before, by electrical circuits and equipment. It was like walking into another world far removed from the academic classroom where a person uses his mind alone. In this Institute men and women were using their minds and their hands to build skills and do those things which will help them to take their proper place in industry.

A school is not just a building, it is made up of people. I was extremely impressed with the calibre of the students. When I first entered the building I noticed there was something different about the young people who were walking around from classroom to classroom or who were working in the laboratories. It took me some time to figure out what the difference was until I saw one of the young men in the hall, who had been working on the house in the building trades section. When I had seen him previously he had been wearing overalls and was dressed like a carpenter on a building site. But when I saw him in the hall later he was wearing a coat and tie and was very

neatly dressed. This was true of all the students. The entire male student body was wearing coats and ties. It was like a scene right out of the business world. These young people were very serious about learning and they dressed like ladies and gentlemen in the process.

I was also extremely impressed with the calibre of the teachers and instructors. Many Canadians feel that there is something second rate about technical and vocational education. Perhaps I had this feeling myself before I visited the Institute. But it certainly disappeared very, very quickly. If the teachers and instructors in institutes of technology across Canada are of the calibre of those in the New Brunswick Technical Institute, then I would say that young Canadians are in good hands.

I would go even further and say that if the institutes of technology and other technical and vocational schools in Canada are on a par with the Institute that I visited, then Canada has a very promising and prosperous future.

WANTED WORKSHOP DIRECTOR

Required to develop a new workshop program of vocational evaluation and adjustment for handicapped persons in modern facilities. He will be responsible for all criteria and procedures used, co-ordination of professional team, and supervision of workshop staff. He must obtain contracts and develop external relationships.

Qualifications will include several years' experience in workshop programs and administration and a graduate degree in psychology, counselling or related field, preferably with the ability to administer and interpret vocational and personality tests.

Liberal fringe benefits.

Apply stating salary expected to:
Executive Director,
The Poliomyelitis & Rehabilitation Foundation of B.C.,
1345 S.W. Marine Drive,
Vancouver 14, B.C.

PARTNERS IN LIVING— SPECIAL EDUCATION AND REHABILITATION

The twelfth annual meeting of the International Northern Great Plains Conference on Special Education and Rehabilitation was held at the University of Alberta in Edmonton in August. Designed to bring together workers in the fields of special education and rehabilitation from the provinces of Alberta, Saskatchewan and Manitoba and from the States of North and South Dakota, Montana and Wyoming, it provided an opportunity for an international exchange of knowledge and experience in the varied aspects of their work.

The delegates were welcomed to the conference by the President, Mr. T. D. Baker, Deputy Superintendent of Public Schools in Edmonton.

Dr. Edgar A. Doll, consulting psychologist in the public schools in Bellingham, Washington, laid the groundwork for an interesting and stimulating conference with his keynote address entitled, "What are the Challenges?". Dr. Doll stressed the importance of imagination and initiative in preparing the disabled for their future. He stated that he had found in his experience that everyone had some area of special interest or competence that could be developed in a realistic way to be applied in some occupation. Stereotyped and traditional methods must be replaced by a realistic approach. In emphasizing the need for competent teachers, he pointed out that what we need in rehabilitation and special education are educated workers in these fields rather than merely trained workers. Training in itself is only a background against which those working in this field must become educated as to the total needs of the job.

Dr. Henry R. Ziel, Professor of Education at the University of Alberta, speaking on "Education for Living," emphasized particularly the importance of educating all individuals to a full realization of the type of world in which they will work. He suggested that there be included in the school curriculum a course in industrial arts, including study of sources of energy available in the world today, new materials that are at our command,

new scientific developments which could be applied in so many fields and the changing society in which we must work. Against such a background all who receive this training would be better equipped to enter any type of employment with a fuller realization of the new resources at their disposal.

The place of the handicapped in society was the subject of discussions with Mr. Ian Campbell, National Co-ordinator, Civilian Rehabilitation, Ottawa, outlining the present day situation and Captain M. C. Robinson, Regional Director, Canadian National Institute for the Blind, from Vancouver, speaking on the prospects for the future.

Mr. Campbell reviewed the progress of rehabilitation attitudes and development of programs in many countries. He referred briefly to new legislation in Canada under which services and facilities may be expanded to bring needed treatment and training to all disabled individuals.

Captain Robinson talked of the great advances that have been made in meeting the problems faced by the disabled and cited further advances that could be made by application of modern scientific developments and techniques resulting in a great widening of opportunity for all disabled persons.

Dr. Allan Roeher, Provincial Co-ordinator for the Province of Saskatchewan, emphasized the importance of proper coordination of services, a better approach to assessment and complete co-operation between governments, voluntary agencies and the whole field of education if we are to make maximum use of all our resources.

Mr. Thomas Moody, of Edmonton, representing employers on a panel discussing the placement in employment of handicapped persons, was critical of those working in rehabilitation. He stated that those who were trying to secure suitable employment for the disabled had an excellent product to sell, but did a poor job of selling. The qualities of reliability and determination that disabled persons possess were the qualities that

[Continued on Page 32]

Recommendation on Vocational Training

Vocational training was one of the matters of major concern at the 46th Session of the International Labour Organization meeting in Geneva last June. More than 1,000 delegates, technical advisers and observers from 92 member countries and seven territories were in attendance. Present also were observers from the United Nations, its specialized agencies, other official international organizations and non-governmental international bodies.

The recommendation concerning vocational training and technical education adopted at this session reflects the current thinking and growing concern in many lands with this matter of adequate education and training to meet the complexities of our modern world.

This recommendation applies to all training designed to prepare or retrain any person for initial or later employment or promotion in any branch of economic activity, including such general, vocational and technical education as may be necessary.

The recommendation emphasizes that training is not an end in itself but must be considered as a means of developing a person's occupational capacities and of enabling him to use his abilities to the greatest advantage of himself and the community. To accomplish this due regard must be taken of employment opportunities. It reiterates the principle that training should be a continuing process throughout the working life of an individual.

The importance of adequate training facilities and the need to facilitate transfer from one type of training to another and to progress from one level to another were recognized.

It also recommends collaboration between neighbouring countries to develop a common network of training facilities when circumstances prevent full national development.

It emphasizes the importance of co-operative planning on the part of public and private bodies in developing fully co-ordinated services.

The recommendation sets out measures that would determine, while respecting the individual's

right to freedom of choice of occupation, the occupations for which training should be given priority and set standards for training institutions with the provision of technical and financial help.

It discusses the importance of vocational guidance facilities along with pre-vocational preparation. It sets out ways and means of providing satisfactory on-the-job training. It makes recommendations regarding the selection and training of teachers and instructors.

It also recommends international co-operation through seminars and working parties, exchange of information, visits, exchange or loan of experienced personnel and accepting selected personnel for training and experience in fields not available in their own country. The possibilities of reciprocal recognition of certificates through establishment of common levels of training and the preparation and exchange of occupational information such as job descriptions which may be particularly useful in the training of migrants were suggested.

This recommendation supersedes the Vocational Training Recommendation, 1939, the Apprenticeship Recommendation, 1939 and the Vocational Training (Adults) Recommendation, 1950. The full text of the Recommendation is set out in the August 1962 issue of the *Labour Gazette*.

CANADIAN CONFERENCE ON SHELTERED EMPLOYMENT

A Canadian Conference on Sheltered Employment was held at the Chantecler Hotel, Ste. Adèle, Quebec, October 2, 3 and 4, 1961.

The conference was sponsored by the Canadian Rehabilitation Council for the Disabled, the name of the new national voluntary organization formed by the merger of the Canadian Council for Crippled Children and Adults (Easter Seal) and the Canadian Foundation for Poliomyelitis and Rehabilitation (March of Dimes). The conference was called at this time because of increasing concern among those working in the

field of rehabilitation for those whose disability, whether physical, mental or emotional, is such that they are unable to compete readily in the open labour market.

The conference brought together individuals with great experience in the operation of various types of sheltered workshops with others working in the rehabilitation field—in rehabilitation centres, health agencies and hospitals, together with representatives of federal and provincial government departments. These included the National Co-ordinator, Civilian Rehabilitation, Canadian Department of Labour, the Department of National Health and Welfare, the Department of Northern Affairs and the Department of Veterans Affairs as well as the Provincial Co-ordinators of Rehabilitation. Also attending were members of the National Advisory Council on the Rehabilitation of Disabled Persons' Sub-Committee on Sheltered Employment. Participants from the United States were warmly welcomed at the conference. Great regret was expressed at the sudden death of Mr. A. R. Bruce, Director of Queen Elizabeth's Training College, Surrey, who was to have been the special guest from Britain and who was to have been brought to the Conference by the Canadian Department of Labour as an expression of its concern and interest in the field of sheltered employment. In all, 140 persons attended the conference.

The aim of the conference was to arrive at some basic principles and, if possible, to make recommendations as to how the need for sheltered employment could be met within the limitations of local economic and geographic areas of Canada.

Chairman of the conference committee and of the opening was Miss Constance Lethbridge, Executive Director, Occupational Therapy and Rehabilitation Centre, Montreal. The official welcome was given by Brigadier James L. Melville, Chairman, National Advisory Council on the Rehabilitation of Disabled Persons and by Mr. Frank McIntosh, President, Canadian Rehabilitation Council for the Disabled.

The opening address, "Planning Creatively for Canada's Disabled" was given by Dr. Keith Armstrong, Acting Executive Director of the Canadian Rehabilitation Council. Mr. Frank Hatcher, Department of Social Welfare, British Columbia, then presented a report on the sheltered employ-

ment picture in the provinces. This was followed by a panel on the influence of local, economic and geographic conditions on the development of sheltered employment. Members taking part in the panel were: Chairman, Mrs. Betty McMurray, Executive Director, Rehabilitation Foundation for the Disabled (Ontario); Mr. Frank Wellard, Provincial Co-ordinator, Nova Scotia; Mr. Edgar Guay, Assistant Deputy Minister of Welfare, Province of Quebec; Mr. Trevor Pierce, Assistant Director, Ontario Welfare Council, Toronto and Mr. C. A. Westcot, Executive Director, Saskatchewan Council for Crippled Children and Adults, Saskatoon.

Dr. Howard Trevethan, Executive Vice-President, Goodwill Industries, U.S.A., introduced Mr. Howard Lytle, President, National Association of Sheltered Workshops and Homebound Programs, U.S.A., who gave an address on the operation of the "Goodwill Industry" type of sheltered employment. Dr. A. H. Goldsman, Psychologist, Occupational Therapy and Rehabilitation Centre, Montreal, presented a paper outlining requirements for a comprehensive program of employment for the handicapped. Dr. Allan Roeher, Provincial Co-ordinator, Saskatchewan, addressed the conference on the importance of sound administration of sheltered workshops. The speaker at the conference banquet was Dr. C. A. Roberts, Executive Director, Verdun Protestant Hospital.

Two afternoons of the conference were given over to small discussion groups, each of which considered a particular aspect of sheltered employment and, where possible, made recommendations. The proceedings of the discussion groups and the recommendations were reported back to the general conference at the close of each day's session. A general summary of the proceedings and recommendations of the conference was presented at the closing session. The chairmen for the three days' sessions were Dr. Oscar Hoffman, Chief, Medical Rehabilitation Division, Department of National Health and Welfare; Mr. Ian Campbell, National Co-ordinator, Civilian Rehabilitation, Department of Labour and Dr. Bertrand Primeau, Medical Director, Rehabilitation Institute of Montreal.

One of the major conclusions of the conference was that the holding of a conference on sheltered

[Continued on Page 32]

THE USE OF TRAINING-ON-THE-JOB (TOJ) OPPORTUNITIES IN REHABILITATION SERVICES

By Milton Friedman, Executive Director
Jewish Vocational Service
Toronto

In vocational rehabilitation the clearest criterion of success is the handicapped person's ability to perform a productive job after treatment. To put it bluntly—the payoff is placement. No doubt there are some exceptions to this rule but, fundamentally, it is unchallengeable.

Increasingly, rehabilitation workers are giving more attention to the vocational components of the rehabilitation process. It is now commonly accepted that medical and physical restorative services alone are not enough to accomplish the basic goal of rehabilitation:—to enable handicapped individuals to assume a productive role in society and find reasonable levels of fulfillment in their personal, social and vocational adjustments.

Vocational Components

What are the vocational components in a good rehabilitation service? They can be categorized in a number of ways, but in essence they can be reduced to three:

- (1) pre-vocational counselling, assessment and work conditioning
- (2) training
- (3) placement

In the judgment of this writer a good rehabilitation program is distinguished by the extent to which it views these elements as inter-related and often inseparable parts of a continuing process.

It is when a less dynamic view is taken that the best laid plans of rehabilitation workers go astray. More than one observer has noted the tendency of rehabilitation centers, hospitals and other institutions to recommend training programs for recovering patients which are *unrealistic* in terms of the patient's abilities, *premature* in terms of his motivation and capacity to withstand the pressures of training, and *impractical* in terms of labour market trends. Invariably these plans fail—at great cost to the community, the standing



Milton Friedman has been Executive Director of the Jewish Vocational Service in Toronto since December, 1948. He is a member of the Advisory Committee on Rehabilitation Services of the Ontario Department of Public Welfare. He is a member of the Board of Directors of the Social Planning Council of Metropolitan Toronto. He has served as Consultant to the Council and carried out a study of the day care needs of homeless older men. He is a professional member of the American Personnel and Guidance Association, and a member of the National Rehabilitation Association.

Mr. Friedman was born in Buffalo, N.Y., and completed his graduate training in social work at the University of Buffalo.

The Jewish Vocational Service established a Rehabilitation Workshop in 1956 to assist in the rehabilitation of handicapped persons. The Workshop is an integral part of the organization's total program which includes vocational counselling, psychological testing, vocational training and job placement services for persons of all ages.

The services of JVS in Toronto are available to persons of all races and creeds.

of the rehabilitation field, and above all else, the self-esteem of the patient.

Pre-Vocational Services

Of the three components identified, the most striking and imaginative developments are taking place in the area of pre-vocational services. Workshops (e.g. the JVS Rehabilitation Workshop

offering controlled work experiences combined with psychological testing and counselling are proving extremely valuable in laying the foundations of sound vocational planning. Though further research is necessary to validate the claims made for these techniques, they seem to be of significant benefit in charting feasible vocational objectives and in conditioning clients for the rigours of training and employment.

In another article we hope to have an opportunity to discuss in detail the Rehabilitation Workshop program of the Jewish Vocational Service which is widely employed in the metropolitan Toronto area for provocational assesment, counselling and work conditioning, especially for convalescent mental patients. Let it suffice in this article to summarize the basic contributions which this twelve-week program (three weeks of assessment followed by nine weeks of work adjustment training) is capable of making towards rehabilitation planning with handicapped individuals:—

- (1) One of the most important prognostic elements in rehabilitation planning, the individual's motivation, can adequately be assessed—indeed it frequently is strengthened as his self-confidence grows in the workshop.
- (2) The individual develops good work habits and perserverance which later can be applied usefully in training.
- (3) Psychological and aptitude testing results become more meaningful when viewed in relation to actual work performance under observation by trained personnel.
- (4) The workshop acts as a stepping stone back into the community as in most instances, the individual continues to live in hospital evenings while working in the shop.
- (5) An inter-agency team develops with a therapeutic focus on the patient. The team consists of staff members of the hospital or referring center, the counsellor from the provincial co-ordinator's office and the JVS Workshop supervisor and counsellor. Each has a separate and distinct role to play and sees the patient from his particular vantage point. Regular interviews with several of the professional team members gives the patient the feeling that many

people are interested in his welfare and actively are supporting his progress.

- (6) Manipulation of therapeutic techniques (i.e. reduction of tranquillizing drug dosage or modification of work pressures), designed to improve the patient's performance or behaviour, can be carried out during the period in the workshop by staff from the referring center or workshop. This can be done with the assurance that changes in behaviour will be noted at once in the controlled workshop setting.

Training On The Job

Having made an allusion to our strong conviction that the foundations of a successful training program lie in proper assessment and work conditioning, we want now to concentrate on the second named component—training—and in particular upon training-on-the-job (TOJ) opportunities. A recent analysis of training programs recommended for handicapped persons in Ontario seemed to support the conclusion that rehabilitation counsellors, as a group, have a restricted view of training opportunities and tend to think in terms of stereotypes—watchmaking, shoe repairing, t.v.-radio repairing, *et al.* By the same token, it revealed that counsellors concentrate on *courses* which are well known and available, rather than on *job goals* which are appropriate for a particular client.

Though conventional training programs such as those mentioned may be very suitable in selected instances, they have drawbacks which cannot be ignored. For example, in most training programs conducted in schools there is no "built-in guarantee" of employment after training. Is there anything more frustrating for a rehabilitation counsellor than to be confronted with a client who has completed his training but for whom no employment can be found? The most popular courses prepare trainees for job areas in which very often there is no particular shortage of personnel. Job finding after training then becomes another in the long line of problems confronting the rehabilitation counsellor and his client. Another complaint frequently voiced about conventional training courses is that they do not keep pace with technological developments, a failing which obviously does not facilitate placement after training. Finally, conventional training

programs frequently are unable to afford the handicapped trainee the opportunities he needs for extra encouragement and support, for a flexible schedule of practice and learning, for experiencing rapid progress and immediate reward (wages or substitute).

For these and other reasons, counsellors in the Toronto JVS are making fuller use of TOJ opportunities. By TOJ we are not referring to informal training programs in which individuals simply are placed on beginning jobs. Rather, we are referring to formal arrangements in which employer, a trainee and the provincial government join together in making a contract. Under the terms of the contract the employer agrees to provide training of a particular nature for a specified length of time and at a stipulated wage rate. The trainee agrees to these arrangements and the province undertakes to pay a share of the approved wage. The province, or its assigned agent, acts in a proprietary role to make certain that the agreement is observed by both parties.

Numerous Advantages

The advantages of TOJ are numerous. It opens up training and employment opportunities on a broad and diversified basis.* Because of the rapid technological changes taking place in industry, new jobs are developing swiftly and industry is turning more and more to training-on-the-job to obtain needed personnel. Although there is no guarantee that the trainee will be offered employment after the training program, it is the unusual employer who does not have this in mind when he enters into a TOJ agreement. The payment of a wage is a great morale booster and stimulates the trainee to put forth his maximum effort to succeed. Psychologically speaking, paying a wage is a first-rate method of reinforcing the learning situation which is implicit in TOJ.

But this does not exhaust the particular values of TOJ. Bernard Berger, assistant director of the Toronto JVS, who has a close and continuing contact with many of the persons moving through the JVS rehabilitation program, sees many values

in TOJ, particularly for the recovering mental patient. In a recent report, he summarized his views as follows:

"In effect the TOJ is an extension of the Rehabilitation Workshop. The employer is given some idea of the patient's personality and his accomplishments in the shop. The TOJ proposed to the employer is based on those vocational and personality attributes revealed through observation of the patient's performance in the workshop and clinical testing.

"The TOJ is particularly useful for those patients who have done adequate work in the workshop setting but who are considered only marginally employable in the competitive industry. For this type of patient placement in a formal school or regular job might prove to be too threatening. The TOJ helps the patient overcome this hump by providing a 'protective workshop setting with a sympathetic employer' while he is adjusting to the demands of the competitive work situation. The patient's shaky self-confidence and self-esteem are enhanced by his acquisition of a trade, occupation or skill no matter how elementary this may be. To him it is the means of warding off the chronic unemployment which has marred his life in the past.

"The TOJ arrangement seems to appeal to the paternal instinct of many of the employers. Recovering mental patients, perhaps more than other groups, fluctuate between periods when their performance at work is excellent and periods when their performance is poor. The employer involved in a TOJ generally will lean over backwards to co-operate in understanding and supporting the patient during his downswings. Naturally, the counsellor must guard against an overly paternalistic attitude as this, too, can be destructive.

Case Summaries

A few case summaries follow to illustrate the organization's use of TOJ and its interrelationship with workshop, counselling and psychological services.

*Training programs have been arranged by JVS counsellors in shipping and receiving, stockkeeping, inventory control, punch press operating, press feeding, upholstering, service station attendant operations, photographic dark room operations, estimating for various industrial groupings, offset press operations, cabinet making, *et al.*

SUBJECT

Male, 21, unmarried.

REFERRAL SOURCE

The subject was referred by an Ontario (mental) hospital in Metropolitan Toronto while still an active ward patient.

DIAGNOSIS

The subject was hospitalized for five years prior to referral. He was regarded as a schizoid personality and was treated with insulin, occupational and psychotherapy.

FAMILY HISTORY

Born to an unmarried mother, a retarded person with a history of behaviour problems, he was made a ward of the CAS when he was eleven days old. He was placed in a foster home which proved to be very inadequate. He was completely rejected by the foster family after hospitalization.

EDUCATION

Subject completed grade 7. His records depict him as withdrawn, evasive, restless and unfriendly. His scholastic achievement was generally poor.

WORK HISTORY

Due to his age at time of hospitalization, subject had no work record. In hospital, he worked in the bake shop and was described as adaptable, co-operative and responsible.

JVS EVALUATION

After twelve weeks of observation in the JVS Rehabilitation Workshop subject was judged to have made good overall progress in responding to work pressures. He responded well to supervision, was co-operative and sociable with co-workers and his productivity was considered comparable to industrial standards. It was found, however, that he needed special encouragement and praise to offset what appeared to be a lack of self-confidence and fear of failure.

JVS RECOMMENDATIONS

On the basis of his performance in the workshop and the results of psychological testing, the subject was considered trainable for manual skills at an unhurried pace, and suitable for work in industry where reasonably understanding supervision was available. It was recommended that TOJ be arranged and that the subject continue to live in hospital for a time. It was felt that JVS counselling facilities should be extended to him during the training period.

JVS ACTION ON RECOMMENDATIONS

JVS counsellor arranged a TOJ for the subject as a trainee in an offset lithography establishment. The training period was for six months, but this was extended to one year.

The subject was seen periodically by his JVS counsellor to review his progress and assist him in coping with problems confronting him in the training situation. The employer showed great interest in the subject and his reports on his progress have been very helpful in counseling the subject. As was anticipated, the subject made steady progress though at a slow pace. He required a great deal of encouragement and support at the outset of his training but his need for this subsided as his confidence grew.

SUBJECT

Male, 21, unmarried.

REFERRAL SOURCE

Ontario (mental) hospital in Metropolitan Toronto area while still an active ward patient.

DIAGNOSIS

The subject had epilepsy since age 5. Seizures were well controlled at the time of referral. Episodes of heavy drinking developed and his behaviour became increasingly unmanageable. He was hospitalized after a suicide attempt and his illness was described as a reactive depressive psychosis. The prognosis was considered poor because of his limited intelligence (border line), poor motivation and difficulties in interpersonal relationships.

FAMILY HISTORY

The subject is a product of a broken home. Before his parents separated there is evidence that they rejected him severely. He was raised by a grandmother.

EDUCATION

The subject completed Grade 7. There is a record of truancy. On recommendation of hospital staff, he enrolled in a watchmaking course at a provincial vocational school and failed.

WORK HISTORY

The subject held a series of unskilled jobs, none of which he could hold for more than three months. He had not worked for four years prior to referral to JVS.

JVS EVALUATION

During a three-week assessment period in the JVS Rehabilitation Workshop, the subject showed enough promise for vocational rehabilitation to warrant his continuation in the workshop for the nine-week work conditioning period.

During the nine-week period in the workshop, he displayed more interest in re-building his life. His productivity steadily improved. He faced his greatest difficulty, however, in co-worker relationships. Psychotherapy at the hospital and JVS counselling was focussed on this area of difficulty. As the nine-week term drew to its close there was noticeable improvement in his ability to control outbursts of anger.

Psychological tests revealed his general ability to be in the dull normal range. There were indications of significant limitations in eye-hand coordination. However, there were no manifestations in actual work performance in the workshop to substantiate these findings.

JVS RECOMMENDATIONS

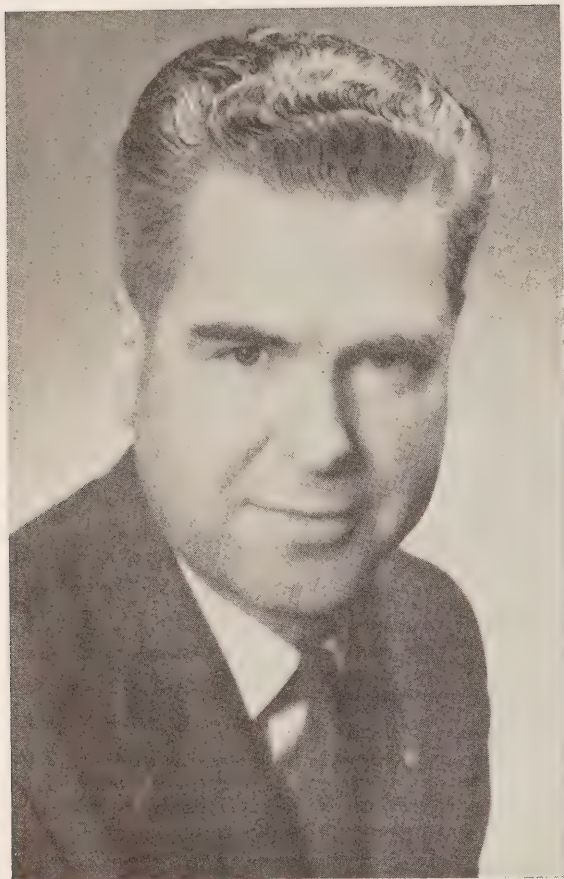
In the light of the history of seizures and limited general ability, a TOJ arrangement was recommended in preference to formal schooling so as to minimize difficulties with placement after training.

ACTION ON RECOMMENDATIONS

The JVS counsellor arranged a TOJ as a stock control clerk in a large automotive parts establishment. The arrangement involved three months of training. The TOJ proceeded smoothly and has lead to steady employment.

[Continued on Page 18]

People And Events



We have learned with regret of the resignation of Mr. G. Wilfred Crandlemire, Director and Co-ordinator of Rehabilitation for the Province of New Brunswick.

Mr. Crandlemire went to work for the New Brunswick Department of Health as Co-ordinator of Rehabilitation on March 1, 1954, and has served as Director and Co-ordinator of Rehabilitation for eight-and-a-half years.

During this period he has served as New Brunswick's representative on the National Advisory Committee for the Rehabilitation of Disabled Persons, and is at present a member of the National Advisory Council.

He is a member of the New Brunswick Coordinating Council for the Handicapped, past president of the Fredericton Civil Service Association, and is president of the New Brunswick Chapter of the Public Personnel Association.

He worked very closely with Mr. Stanley Cassidy in the building and equipping of the Forest Hill Rehabilitation Centre and has, with his staff, built up a fairly comprehensive rehabilitation program in New Brunswick.

The rehabilitation program includes assistance for any rehabilitation procedure that is required for the disabled of the province who need assistance. Complete medical, vocational and social assessment can be provided and any medical rehabilitation treatment that is recommended can be paid for and provided under the program.

Vocational training has been provided through Schedule "R", now Program 6, and job placement and follow up is provided through the liaison officer and special service officers of the National Employment Service as well as by the five rehabilitation officers on the staff of the Rehabilitation Branch.

The vocational training program was instituted in the summer of 1954 and the medical rehabilitation program began in 1957. Since that time 700 people have been treated and over 600 have been provided with vocational training.

During his period as Director of Rehabilitation more than 1400 people have been rehabilitated through the rehabilitation program.

Mr. Crandlemire is a graduate of Teachers College and the University of New Brunswick and prior to coming to work for the Department of Health taught 18 years in the schools of the province.

He leaves the Department to become Executive Director of the newly-established Industrial Safety Council, effective November 1. He will be greatly missed in the rehabilitation field but the best wishes of his many friends go with him to his new post.

Manitoba Minister of Health Opens New Rehabilitation Hospital

An important milestone in providing medical service to the people of Manitoba was the formal opening of the Manitoba Rehabilitation Hospital in Winnipeg. On Friday, September 14, representatives of health and welfare organizations in the province, and friends and members of the Sanatorium Board of Manitoba, gathered in the

hospital's outdoor court-yard to watch the Hon. George Johnson, M.D., Provincial Minister of Health, perform the opening ceremony.

The Sanatorium Board is very proud of the beautiful new medical facility which it now operates for the people of Manitoba. The first of its kind in the province, and one of the best equipped and best planned rehabilitation hospitals on the North American continent, it will fill a great need in our communities for a centre to provide special care to the sick and disabled.

The hospital is an impressive structure occupying a full city block in Winnipeg's complex Manitoba Medical Centre. It comprises a six-storey main hospital section, containing accommodation for 158 in-patients and 200 out-patients daily, a separate, four-storey, 64-bed tuberculosis treatment and diagnostic wing, and single storey treatment areas.

The hospital also houses the University of Manitoba's new School of Physiotherapy and Occupational Therapy, and the Sanatorium Board's executive offices.

The aim of the Manitoba Rehabilitation Hospital is to offer to those who are physically disabled, chronically ill or convalescing, an intensive program of treatment to help them to live and to work to their utmost capacity.

To carry out this objective it provides services and facilities which cover the whole spectrum of physical medicine and rehabilitation. These include physiotherapy and occupational therapy, speech therapy, psychotherapy and medical social services, brace making and the fitting and training in the use of prosthetic appliances. It also has a department to evaluate a person's rehabilitation potential.

The hospital will have an important function as a teaching centre for persons interested in rehabilitation work, as a centre for research in the field of physical medicine, and as a centre where other allied agencies can work together with the hospital staff.

(From the News Bulletin of the Sanatorium Board of Manitoba)

Helping the Multi-problem Family

The concern about the needs and difficulties posed by the multi-problem family is world-wide. In Vancouver, study tends to bear out the assumption that a relatively few families receive the bulk of the welfare dollar. The same families are in need of welfare services over several generations. The Vancouver project shows that a handful of troubled families costs nearly half of all the time and money spent on subsidized health and welfare. The people of these families are poor, many suffer ill health, they live in squalor, they have no hope. Their children are born in this environment and may never know anything better.

A pilot scheme for co-ordinated services to a group of such families has been set up in Vancouver with the co-operation of a number of agencies.

In the area selected for study, with about 200 families involved, all health and welfare services likely to be required will be located in one central place. The staff will consist of about 15 persons, certain agency staff being seconded to this project for a period of three years. A detailed evaluation will be made of what has been done and a control group of 200 persons outside the project will be studied. It is anticipated that at least 10 years will have to elapse before a proper evaluation can be made of the project.

This experiment will be watched with great interest by many others concerned with the same problem.

War Disabled to Aid Civilian Amputees

The War Amputations of Canada have announced the creation of a new program to aid civilian amputees. Through it, the organization will share its experience and facilities in rehabilitation and training for the benefit of civilians who have undergone amputations.

The program will provide an advisory service for persons who have suffered the loss of a limb or limbs. This advisory service will extend to the family and relatives and should be of particular value in advising parents of young child amputees.

Information and demonstrations regarding prostheses and orthopaedic appliances will also be provided.

Dr. Arthur MacNamara

The death occurred in Ottawa on October 4, at the age of 79, of Dr. Arthur MacNamara, former Deputy Minister of Labour, and architect of the wartime mobilization of manpower program in Canada.

Dr. MacNamara served in a number of government posts in Manitoba before being released to the Federal Government in 1940 to organize the Dependents Allowance Board. He then served as Acting Chief Commissioner of the Unemployment Insurance Commission before becoming Director of National Selective Service. In 1943 he was appointed Deputy Minister of Labour.

His success in the mobilization of Canada's manpower resources was recognized and his plan copied by other countries. Following the war, his was the guiding hand that steered the return of workers back from defence industries into a peacetime economy with a minimum of lay-off and dislocation. For his outstanding contribution to the nation the King, in 1946, made him a Companion of the Most Distinguished Order of Saint Michael and Saint George. The University of Manitoba conferred on him the honorary degree of Doctor of Laws. He continued as Deputy Minister of Labour until 1953, playing a vital role in the complex post war reconstruction period. It was under his guidance that the Civilian Rehabilitation Branch was established.

Following his retirement from the post of Deputy Minister he continued to lend his wisdom and advice to the government as special adviser to the Department of National Defence on the employment of civilians.

In paying tribute to an outstanding civil servant, the Honourable Michael Starr, Minister of Labour, had this to say: "Arthur MacNamara was a warm and human personality. In his long career he made an enormous number of friends and acquaintances. It is eloquent testimony to his forthrightness and soundness of judgment that even those with whom he was at times in conflict never lost their affection for him. He will be widely mourned".

Training for Disabled Persons

During the year April 1, 1961 to March 31 1962, 2,765 disabled persons were enrolled for training in Program 6 under the Technical and Vocational Training Assistance Act. Of this number 640 (428 men and 212 women) were continuing with training begun earlier, while 2,125 persons (1,300 men and 825 women) were new enrollments. Two hundred and eleven persons received their training by training-on-the-job. A wide variety of training was provided as may be seen by the list of courses given during the year:

Academic Courses: Bachelor of Arts, Art, Fine Arts, Honour Chemistry, Chemistry, Geography, Honour Maths & Physics, Language & Literature, Meteorology, Modern History, Political Science, Social Sciences.

Engineering & Technology: Engineering, Engineering Science, Electrical Engineering, Civil Engineering, Chemical Technology, Electronics, Electronic Technology, Radio and Television Electronics, Aeronautical Technology, Mechanical Technology.

Business Administration: Business Administration, Commerce and Finance, Accounting, Advertising, Designer, Salesmanship, Quality Control, Subscription Agent, Show Card Writing, Advertisement Checker, Assembler, Secretarial Science, Dictaphone Typist, Commercial Training, Business Machines, Switchboard Operator, Stand Operator.

Health, Education, Welfare, and other Services: Medicine, Medical Librarian, Pharmacy, Dental Technician, Dental Assistant, Laboratory Technician, Public Health Nursing, Male Nurse, Nurse's Aides, Artificial limb and brace making, Social Work, Law, Journalism, Veterinary Medicine, Field Secretary, Pedagogy, Teaching, Home Teacher, Home Economics, Vocational Counselling, Speech Therapy, Photography, Interior Decorating, Forest Ranger, Barbering, Domestic Science, Cooking, Hairdressing & Beauty Culture, Homemaking.

Trades, Industrial and other occupational Training: Drafting, Blue Print Reading, Carpentry, Television Radio and Television Repair, Electricity and Electrical Appliance Repair, Motor Mechanics, Diesel, Motor Rewinding, Outboard Marine, Heavy Duty Mechanics, Millinery, Power Sewing, Tailoring, Dressmaking, Invisible Mending, Dry Cleaning, Camera Repair, Watch Making, Watch Repair and Jewellery, Shoe Making, Shoe Repair, Restaurant Cooking, Business Machine Repair, General Shop, Machine Shop, General Technica Auto Body, Welding Machine Operator, Oil Burner Servicing, Plumbing and Pipe Fitting, Stationary Engineering, Printing, Cabinet Making, Woodfinishing, Woodworking, Basket Making, Broomwinding, Clay Modelling, Silkscreen Processing, Packaging and Assembly, Hand Folding Envelopes, Floristry, Greenhouse Operator, Driving Lessons, Work Adjustment Training.

Boston University Summer School Program Rehabilitation Counselling

In an attempt to meet the need for professionally-trained counsellors in the United States a summer school was established in the School of Education at Boston University several years ago. This program is under the direction of Dr. Myers, a former counsellor himself, who believes that the trained rehabilitation counsellor must have a complete understanding of the problems of, not only the physically disabled, but also the mentally retarded and the emotionally disturbed.

This summer course in rehabilitation counselling consists of two six-week semesters, as indicated below:

Semester 1

Philosophy and Principles of Rehabilitation

1

Concepts in Personality Theory

Psychological Tests in Guidance

Counselling—Theory and Practice 1

Practicum in Rehabilitation Counselling

Semester 2

Philosophy and Principles of Rehabilitation

2

Abnormal Psychology

Case Studies in Guidance

Medical Orientation to Rehabilitation

Practicum in Rehabilitation Counselling

Seminar in Rehabilitation Counselling

Methods of Educational Research

Each semester consists of twelve two-and-a-half-hour lecture periods in each subject of the course while the practicum course provides for twice-weekly trips to various rehabilitation centres, both medical and vocational with a lecture discussion period once a week.

Of interest, also, is an annual two- to four-week institute on the rehabilitation of emotionally disturbed persons. This is apart from the course in rehabilitation counselling but is available to interested summer school students.

This course, although designed for American students, is available to Canadians. While in a

few instances the emphasis is on the American point of view the essence of the course is applicable to Canadian philosophy and practices.

A few Canadian students have attended the Institute on the Rehabilitation of the Emotionally Disturbed. This summer two rehabilitation counsellors from Nova Scotia have taken advantage of the opportunity to attend the course in rehabilitation counselling with a view to increasing their knowledge in their chosen field of work.

Everett Allan Green Accepts New Post

Everett Allan Green, since 1956 a rehabilitation counsellor with the Rehabilitation Branch of the Department of Health, Nova Scotia, has accepted the newly-created position of Supervisor of Provincial Vocational Schools in that province.

Following his graduation from high school in Sydney, Mr. Green worked for seven years as a stamper in the steel mill of the Dominion Steel and Coal Company. He then served with the RCAF for four years. After discharge, he went to work in a dairy but then decided to use his re-establishment credits to further his education. He registered at St. Francis Xavier University, graduating with his Bachelor's Degree in Arts and Education. He served for two years on the teaching staff of Sydney City and then joined the Tuberculosis Control Division of the Department of Public Health, serving as a Rehabilitation Supervisor in the tuberculosis units attached to three general hospitals in the Cape Breton area. In 1956 when the tuberculosis units closed he began his duties with the rehabilitation division of the Department which was developing and expanding under the Co-ordination of Rehabilitation of Disabled Persons Agreement.

Many handicapped persons in Cape Breton and on the mainland credit Everett Green with their rehabilitation to lives of usefulness and economic self-sufficiency. With his background of industrial experience and vocational counselling he is well qualified for his new position. While he will be missed in the ranks of rehabilitation workers, all who knew him and worked with him wish him well in his new position.

Mr. Green with his wife and family will reside in Halifax.

A New Colour Film

"Stepping Stones," a new colour documentary film prepared for the Ontario Workmen's Compensation Board, shows how an injured workman, step by step, responds to treatment, regains his confidence despite his handicap and is able to make the adjustments necessary for a return to work.

The scene is laid in the Board's Hospital and Rehabilitation Centre at Downsview. The only professional actor in the film plays the part of the injured workman with the other parts portrayed by persons at the centre.

"Stepping Stones" is available for showing to organizations or interested groups. Copies of the film may be obtained from the Librarian, Workmen's Compensation Board, 90 Harbour St., Toronto or from district representatives of the Compensation Board at Port Arthur, Windsor, Ottawa, Kitchener or North Bay.

[Continued from Page 21]

every employer is seeking. The rehabilitation worker was much too apologetic in approaching employers and should approach them with confidence as placing a reliable disabled person at work was doing the employer a favour.

A number of group sessions, led by outstanding workers in the varied aspects of special education and rehabilitation, provided opportunity for an exchange of ideas and experiences on a broad range of matters involved in the education and rehabilitation of disabled persons.

Altogether the conference was an educational and provocative experience. The delegates returned home with a broader understanding of the inter-relationship of education and rehabilitation. The increasing understanding and co-operative thinking displayed at this conference augurs well for future program development.

[Continued from Page 23]

employment at this time was well justified in that it afforded an opportunity for those most closely concerned with provision of sheltered employment to come together to assess the needs for such services in Canada, to discuss the existing programs and share problems and to make a start on providing answers to some of the questions of how the employment needs of the disabled are

to be met within the context of a comprehensive rehabilitation program.

In keeping with this beginning it was decided to maintain the interest and action engendered by the conference by the establishment of a permanent conference committee and the possible holding of another conference within two to three years. The conference committee will be preparing a full report of the conference and its recommendations for later publication by the Canadian Rehabilitation Council for the Disabled.

Rehabilitation Offices in Canada

NATIONAL OFFICE

National Co-ordinator,
Civilian Rehabilitation,
Department of Labour,
OTTAWA, Ontario.

PROVINCIAL OFFICES

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Department of Health,
Post Office Box E5250,
ST. JOHN'S, Newfoundland.

Deputy Minister,
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Provincial Rehabilitation Co-ordinator,
Department of Public Health,
Post Office Box 488,
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Director and Co-ordinator of Rehabilitation,
Department of Health,
FREDERICTON, New Brunswick,

Physically Handicapped Division,
Department of Youth,
9175 St. Hubert Street,
MONTREAL 11, Quebec.

Provincial Co-ordinator of Vocational Rehabilitation,
Department of Public Welfare,
85 Eglinton Avenue East,
TORONTO 21, Ontario.

Provincial Co-ordinator of Rehabilitation Services,
Department of Health,
Room 615, Norquay Building,
WINNIPEG 1, Manitoba.

Provincial Co-ordinator of Rehabilitation,
Health and Welfare Building,
REGINA, Saskatchewan.

Provincial Co-ordinator of Rehabilitation,
Department of Public Welfare,
109th Street and 98th Avenue,
EDMONTON, Alberta.

Rehabilitation Co-ordinator,
Department of Health Service and Hospital Insurance,
828 West 10th Avenue,
VANCOUVER 9, British Columbia.

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1963



Rehabilitation **IN CANADA**

published in the interests of Canada's Disabled by ...

CIVILIAN REHABILITATION

Department of Labour Canada

CONTENTS

Page

- 4 The Placement Agency in Canadian Rehabilitation
- 6 The Handicapped and Employment
- 8 The Employment Liaison Officer
- 9 I Have No Objection To Hiring A Handicapped Person
- 10 Happy In Employment—Through Special Placement Service
- 12 Chamber of Commerce and Employment of the Handicapped
- 13 Organized Labour Supports Rehabilitation
- 14 Job Placement Services For the Deaf and Hard of Hearing
- 18 Don't Undersell Your Product
- 20 President's Committee On Employment of the Handicapped
- 23 We Are Proud of Our Handicapped Employees
- 23 Services for Older Workers
- 25 Pan-Pacific Seminar on Rehabilitation of Disabled
- 26 People and Events

This bulletin is prepared by Civilian Rehabilitation, Department of Labour, with the co-operation of the Department of National Health and Welfare, the Department of Veterans Affairs, the National Employment Service and governmental and private agencies interested in the rehabilitation of Canada's disabled.

"The ultimate goal of all rehabilitation is to enable the handicapped individual to work. . . . a job is essential not only to enable the individual to be economically self-supporting but also to assure him his rightful place in his home and his community."

HALL H. POPHAM, President,
International Society for Rehabilitation of the Disabled

"We all recognize that rehabilitation is not an end in itself, but only a means to an end. Its purpose is to change the disabled person from a state of dependence to one of independence, from disability and helplessness back to ability and usefulness at work. Resettlement in employment is the crux of the whole process of rehabilitation."

DAVID A. MORSE, Director-General,
International Labour Organization

To Our Readers

THE IMPORTANCE of employment as the most desirable goal of all rehabilitation effort cannot be over-emphasized. The disabled themselves desire the opportunity to be self-supporting as far as possible, to contribute something to the economic well-being of the community and to enjoy the satisfaction of accomplishment. This requires the planning and co-operation of governments, voluntary agencies, industry and labour, and the interest and support of all citizens. If these satisfactions are to be the lot of the handicapped some special efforts must be made by them and on their behalf.

The International Labour Organization in its Recommendation on Vocational Rehabilitation of the Disabled emphasizes the importance of employment and promulgates certain suggestions designed to aid in increasing job opportunities. Part VII of the recommendation says: "Measures should be taken, in close co-operation with employers' and workers' organizations, to promote maximum opportunities for disabled persons to secure and retain suitable employment. Such measures should be based on the following principles:—disabled persons should be afforded an equal opportunity with the non-disabled to perform work for which they are qualified; disabled persons should have full opportunity to accept suitable work with employers of their own choice," and "emphasis should be placed on the abilities and work capacities of disabled persons and not on their disabilities".

This issue focusses attention on the employment of the disabled and on services of job-counselling and placement for the disabled in Canada. We hope it will extend knowledge of the efforts going on to improve and increase services that are vital to the success of rehabilitation and the occupational future of our disabled citizens.

The National Employment Service

THE PLACEMENT AGENCY IN CANADIAN REHABILITATION

By C. A. L. Murchison,

Commissioner, Unemployment Insurance Commission

The goal of the National Employment Service is to make each of its local offices the focal point in the employment life of the community.

In this role the local office co-operates with employers, unions, educational and training institutions, community groups and other agencies to achieve the maximum employment, economic growth and development of the skills of the work force.

Obviously this requires making maximum use of the abilities of all of Canada's human resources.

Policy of National Employment Service

Since its inception the policy of the National Employment Service has been to endeavour to refer to suitable employment any resident of Canada of whatever occupation or calling. Within this policy, recognition has been taken of competent handicapped workers who are able and willing to perform work of a competitive nature alongside their fellow workers.

Without restricting the employment rights of other persons, the National Employment Service gives special assistance to these competent, well-motivated workers who require assistance in securing suitable employment placement.

Assistance to Disabled

In achieving its aims with regard to handicapped workers, the National Employment Service fulfills its responsibilities in the broad program of rehabilitation in various ways.

The National Employment Service assists in the rehabilitation of handicapped workers by advising about employment aspects to be considered when a



C. A. L. Murchison has been Commissioner of the Unemployment Insurance Commission since 1947, and is a member of the National Advisory Council for the Rehabilitation of Disabled Persons. Mr. Murchison was born in Manitoba. He interrupted his education to spend four years in the Canadian Army during the First World War. He graduated from the University of Manitoba with a degree of LL.B. and practiced law in Winnipeg until 1941 when he came to Ottawa to organize the Legal Division of the War Time Prices and Trade Board. In 1944, he became secretary and later chairman of the National Labor Board. In June 1947, he was appointed to his present position. Mr. Murchison served on a Committee of the International Labor Organization created to establish standards for Social Security. He also acted as chairman of the Interdepartmental Committee set up to study a rehabilitation plan for disabled persons in Canada which led to our present Federal-Provincial Vocational Rehabilitation Program.

rehabilitation program is being planned for an individual, it helps to evaluate handicapped workers in relation to occupational demands and current labour market conditions, and endeavours to place in suitable employment those workers who are capable of performing adequately the duties of the job.

Factors Favouring Employment of the Disabled

In its work in placing handicapped workers, the National Employment Service has become aware of a number of trends in industry, in personnel practice, and in public attitudes which are favourable to increased employment of handicapped workers. The most effective factors contributing to the enhancement of employment opportunities for handicapped workers are the growing familiarity with, and the acceptance of, selective placement techniques. Selective placement is simply the recognition of a basic principle that individuals, like jobs, are different. More and more employers are analyzing individual jobs to determine actual physical and other requirements for performance, and assessing the physical capacities of handicapped workers in order to be able to compare the workers' physical capacities with the physical demands of jobs for which they may be qualified.

This approach to the selection of handicapped workers has resulted in many more opportunities being opened, rather than restricted, to these workers as so frequently happened when less selective methods were used.

Another factor assisting handicapped workers to gain employment more easily is the increasing awareness on the part of employers and the general public of the efficacy of rehabilitation. The realization that rehabilitation can restore the work capacity of disabled persons, frequently enabling them to be more skillful workers than they were before impairment, has led many employers to accept rehabilitated workers.

To-day, handicapped workers with virtually all types of disability are successfully performing jobs in almost every conceivable occupation because their abilities have been found to be adequate for job performance, and their disabilities not to be a restricting factor. The increased knowledge of the capabilities of qualified workers who only happen to be physically handicapped has done much to reduce the rejection of such workers which resulted from lack of knowledge of the potentialities of the handicapped.

Increased Opportunities with Automation

Expanding mechanization and automation in industry, commerce and business promise greater opportunity for employment of handicapped per-

sons in these fields. Mechanization and automation have substantially reduced or eliminated physical effort, manual dexterity, visual acuity, and other activities required of workers to perform many jobs. Now, workers may perform an increasing number of jobs with the aid of powered devices or control the production process by means of control panels. Such changes in the manner of producing goods and performing services have made, and will continue to place, a constantly growing number of jobs within the capabilities of persons with impaired or limited physical capacities. It should be noted, however, that this transition imposes greater mental and intellectual demands upon workers and requires greater educational and training preparation of the worker to qualify him for jobs involving mechanization and automation. It is significant, also, that automation and mechanization are being introduced extensively in the business and commercial fields in which professional, office and sales jobs abound. In the current decade, such jobs are expected to have the fastest growth, and will afford many opportunities for handicapped workers.

Utilization of the skills of handicapped workers in productive employment is sound and necessary, both for the contribution handicapped Canadian workers can make to our national productivity and for the sense of independence and well-being they can derive from doing a good job.

The National Employment Service, in carrying out its role as the employment placement member of the rehabilitation team, is charged with the task of finding suitable workers for employment and suitable jobs for capable workers. It matters not that capable workers may be handicapped for it is the workers' competency which provides the basis upon which the National Employment Service is able to fulfill its responsibility in the rehabilitation plan.

The National Employment Service will endeavour to continue to provide the best service possible to handicapped Canadian workers.

Change of Name

Because of the growing importance in the United States of the work being done by the Office of Vocational Rehabilitation it will, from now on, be known as the Vocational Rehabilitation Administration. Miss Mary Switzer, who has ably directed this program since 1950, will head the Administration with the title of Commissioner.

THE HANDICAPPED AND EMPLOYMENT

By

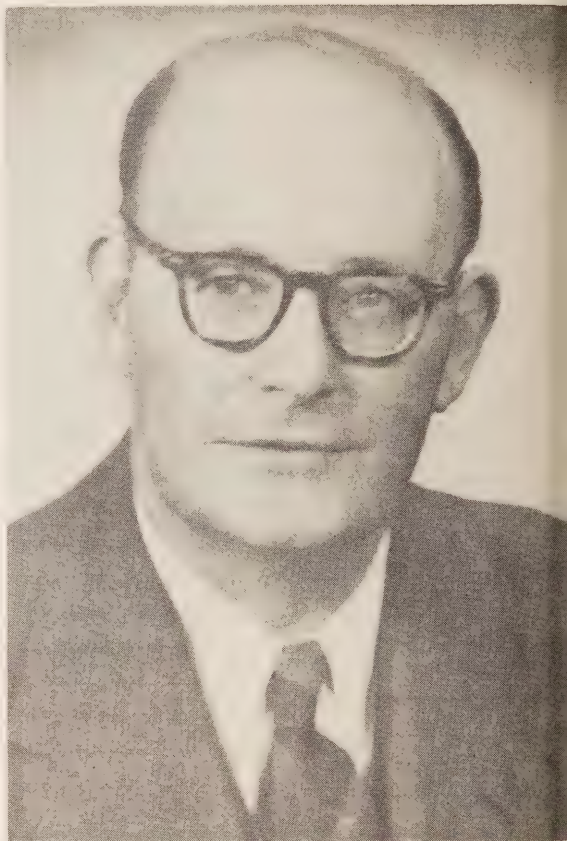
William Thomson, Director,
National Employment Service

In our article in the 1962 spring issue of *Rehabilitation in Canada*, mention was made of ILO Convention 88, which charges national public employment services with effecting the best possible organization of the labour market as an integral part of the national program for the achievement and maintenance of full employment and the development of productive resources. That Canada has accepted the principle is demonstrated by Section 25 of Part II of the Unemployment Insurance Regulations, which states: "The aim of the employment service is the organization of the employment market as an integral part of a program for the achievement and maintenance of the highest possible level of employment".

Experience since World War II has clearly and convincingly demonstrated that the handicapped have a significant contribution to make to a nation's productivity. It follows, then, that the Employment Service objectives, as stated above, can be met only if the handicapped are given adequate opportunity to make their contribution. Since organized rehabilitation is designed to provide such opportunity, the NES sees the rehabilitation program as a valuable ally in avoiding wastage of manpower and in achieving maximum productivity.

Satisfactions of Employment

Employment is probably the most important security factor in the life of the individual who must earn a living, and this means most of mankind. About one-third of the average man's life is devoted to work. Employment not only provides some degree of economic independence; it gives meaning and purpose to life and contributes to the well-being and morale of the individual and the family. Although the handicapped person may have been deprived of some of his abilities, he still retains the basic human needs to be financially independent, to be a participant in the labour market and to contribute his share to the life and economy of the community and the country. Employment, therefore, is a very significant factor in



William Thomson is the Director of the National Employment Service of the Unemployment Insurance Commission. Mr. Thomson was born in Scotland and most of his schooling was obtained there. Following military service, he came to Canada in 1927 and was employed in the Dominion Bureau of Statistics. He acted as Director of Licencing for the War Time Prices and Trade Board before joining the Royal Canadian Navy where, at the end of the war, he played an important part in discharge counselling. He returned to the Dominion Bureau of Statistics in 1946 but soon transferred to the National Employment Service as a specialist in Occupational Research and Labour Market Information. He became Director of the Employment Service in 1956.

the life of the handicapped person, and, of course, in any individual plan of rehabilitation. The NES accepts the responsibility laid on it in these regards and I think it fair to say that despite some limitations of staff, is doing a creditable job.

Help in Rehabilitation Planning

National Employment Service staff are privileged to participate with workers in other fields of endeavour to achieve the objective of the complete rehabilitation program—the restoration of the individual to a productive, fruitful existence as a significant member of the labour force and of society in general. In larger centres across the country, through its counselling and selective placement service to the handicapped, NES is contributing to organization of the labour market by providing assistance in solving the employment problems of rehabilitants. It participates with the provinces in identification of suitable training programs for individuals and in channeling the trainees into appropriate courses. After training is completed, the NES accepts the trained rehabilitant for selective placement when such is indicated.

Relations with Employers

To facilitate placement, the employment service conducts an on-going program of public relations among employers and other members of the community, explaining, interpreting and demonstrating the abilities that properly screened and trained rehabilitants can offer to industry. Through visits to employers, analysis of job requirements and study of job performance, special services officers become aware of suitable vacancies in the community that can be adequately filled by well-motivated, trained handicapped persons.

The importance of adequate preparation for employment cannot be over-stressed. In a free enterprise system, the employer must produce his goods or services at competitive prices or he fails

to remain in business. For this reason employees must be capable of competitive employment—of giving a fair return in terms of production for wages paid. This is an essential factor in satisfactory employer-employee relationships, without which no business can survive. Fortunately, it has been clearly established that by rehabilitation service a great many of the handicapped can be restored to the extent that they can perform competitively in the open labour market; these are possible of placement although they may have some residual disability.

There will be some, however, for whom it is not possible to reach the competitive level of employment. These persons still have the desire, and the need, to be financially independent and to contribute to society as much as their individual circumstances will permit. This is the basic reason supporting the establishment of sheltered workshops and the organization of homebound employment. Although these activities fall outside the NES orbit, they are an important sector of the overall rehabilitation picture and contribute in their own way to national productivity.

The National Employment Service is concerned with the organization of the open or competitive labour market and has equipped itself to assist with occupational planning and subsequent training for rehabilitants, when indicated. When, as a result of rehabilitation services, handicapped persons become capable of performing satisfactorily on the open labour market, the National Employment Service makes every possible effort to place them in the jobs best suited to their individual abilities and needs.

A Blind Worker A Capable Worker

Blind for the last 15 years, Wally Kennedy has been employed for 10 years in the highly-mechanized Canadian General Electric plant in Barrie, Ontario. Having worked at various jobs in the plant, he is at present employed in sandblasting of soleplates of electric irons. Wally's keen sense of touch helps him to assure the smooth mirrorlike finish required for good ironing. He also works at inserting field coils in vacuum cleaner motors. This calls for considerable dexterity and care.

His employers speak highly of his skill and careful workmanship. They find him most co-operative.

His fellow workers are frequently amazed at his ability to find his way around among the machinery, conveyors and materials of the plant.

Wally is a member of the church choir and a much sought-after baritone soloist.

Wally Kennedy is typical of the hundreds of blind Canadians who are making their contribution to the economic and social life of Canada.

THE EMPLOYMENT LIAISON OFFICER HIS ROLE IN PLACEMENT OF THE DISABLED

By Robert MacCormack

The evolution of the handicapped individual into a self-supporting citizen capable of holding his own in our competitive labour market is the goal of the Federal-Provincial Vocational Rehabilitation Program and the National Employment Service.

The complexity of administrative policies and procedures today demand the utmost co-operation, understanding and communication of numerous departments and agencies likely to be involved if the handicapped individual is to be fitted into employment. The NES in recognizing this need for teamwork established the position of employment liaison officer to co-ordinate and promote the placement of the handicapped.

The successful rehabilitation of a disabled person depends on many factors: training has to be in occupations which can absorb workers, and applicants would have to move from one centre to another to take advantage of job opportunities that would occur in their skill.

Co-ordination of Services

The vocational rehabilitation program in most provinces is decentralized into regional offices. Case conferences, at which individual rehabilitation plans are developed, are held at each of these centres.

To assist in this planning, the liaison officer travels to each conference and participates as an employment advisor on job requirements and occupational demands.

When the handicapped person has completed his vocational training and is ready to seek a job, he is sent by the rehabilitation worker to the employment office servicing his area to register for work. A summary of the applicant's disability, training and capacity for work is provided by the social worker and a copy of this summary sent to the employment liaison officer.

After exploring the local opportunities for placement, the local office reports the result to the employment liaison officer. If the prospects for a job in his skill are poor there but the applicant is well qualified, the ELO discusses with the Supervisor

of Rehabilitation the desirability of moving the applicant to a job elsewhere. If he is willing to move, a copy of the social worker's summary and the employment application are sent to the special services officer in whichever employment office the liaison officer believes there may be a demand for his skill. This process is repeated, office by office, until either a job is located or it is determined the applicant does not have the requirements to enter competitive employment.

When a job opportunity is located, the special services officer advises the liaison officer, who arranges with the rehabilitation authority to have the applicant visit this office for an employment interview, with transportation provided.

A Successful Placement

Typical of the type of success that has been experienced, is the case of Mervin, a 21-year-old man who had been stricken with polio in 1959. This had left him with a severe trunk and shoulder involvement. Through the vocational rehabilitation program he received training in drafting and, on completion of the training, was referred to the employment office at Saskatoon. A suitable job opportunity could not be found in Saskatoon so through the employment liaison officer, his application was sent to the special services officer in Regina. The Regina NES office located an employer who had an opening for a draftsman and who, after hearing about Mervin's qualifications, was interested in interviewing him for the position. Through the liaison officer, it was quickly arranged for the Department of Social Welfare to bring Mervin to Regina to apply for this job. Mervin was in Regina the next day, interviewed by the employer and hired for the job.

Since the handicapped applicant has to compete for jobs with other applicants his work skills must therefore, be just as good. Through selective placement he is fitted into a job where his disability does not affect his production.

Not all of the disabled who are referred to the

(Continued on Page 24)

"I HAVE NO OBJECTION TO HIRING A HANDICAPPED PERSON"

By Bernard MacKenzie

On October 8, 1959, George Williams left home at 6.30 A.M. as he did on every other working day of the week to go to work 42 miles west of the city. The weather was brisk and snow flurries filled the air. The highway was icy and George drove with extreme caution. After leaving the main highway he could hear that familiar sound as the millwright had already started the power unit of the sawmill. In approximately 15 minutes another day's work would commence. George had just time to have coffee at the cook house with the single men who lived at camp.

At 8 A.M. all were in their positions. George was trimmer-man and another day's work had started. At 11.35 A.M. the millwright pulled the main switch of the power unit. George Williams had several years experience in sawmilling. It happened so quickly that no one will ever know exactly what happened. George Williams fell into the trim-saw. Two fingers of his right hand were severed. His thumb and index finger remained intact. He suffered multiple injuries to his chest and right arm.

Treatment of Injuries

Under Workmen's Compensation he underwent treatment for his many injuries. He was finally released from treatment after 16 months. It was the opinion of the doctors and rehabilitation officers of the Board that he should follow another pattern of employment as the assessment of his condition indicated that he could not return to sawmilling or any such type of work. George was referred to the National Employment Office on February 17, 1961 for further counselling and placement. He was interviewed and registered for employment by the special services officer. During the next two months he called into the National Employment Office twice a week, and during this period employment in another occupation was planned with him.

George Williams dropped out of school nineteen years ago while attending grade 8. His life was that of the out-doors, following sawmilling and con-

struction all his life. His entire employment history revealed that his work was of a seasonal nature. He made big money when he worked. However, approximately two-and-a-half months of each year were spent at home due to spring and fall road break-up periods.

Counselling

During the first counselling interviews our applicant was extremely doubtful as to whether anyone could be of assistance in developing a vocational plan that would ultimately lead to suitable employment. He was greatly concerned, not only about his own future, but also that of his wife and two daughters in grades 2 and 5.

George Williams was no different from other applicants who found it necessary to change their whole way of life. It seems that there are two major hurdles to surmount before discussing a tentative vocational plan with such an applicant. Once the individual becomes reconciled to the fact that he is not the physical person he was prior to injury and that his earning capacity, at least in the initial stages of his new employment, is going to be much less, a vocational plan may be discussed.

First Counselling

During the following counselling interviews it was found that George Williams had absolutely no interest in furthering his academic education nor had any desire to leave home for vocational training. He missed his wife and young children immeasurably during his lengthy period in hospital and his mind was set that he would never again leave his family for such a lengthy period. George, however, did consent to endeavour to improve his writing by practising one hour each day.

After the sixth counselling interview the following was concluded:—

1. that the applicant must receive on-the-job training within the city where he would be close to his family,

2. that the training must be of a nature where his experience and previous knowledge would be of maximum value to augment not only his physical handicap but also his lack of academic education.

Final Interviews

Final interviews disclosed that George had an excellent knowledge of sawmill machinery. He was fairly well versed in the technical names of parts used in the construction of a sawmill. He knew the jargon of employers in the sawmill business in this area.

After considerable deliberation it was decided that employment in a parts department of an industrial equipment firm that had a volume of business in the sale of sawmill parts would be suitable to George's interests. It would also be employment where his previous knowledge and experience would prove invaluable. Fortunately, there were such firms in the city.

Our applicant displayed keen interest in this plan. He doubted the possibility of arranging such employment due to his lack of education and his ability to write quickly. His writing had improved considerably during the past two months, however, but his speed did not improve.

Employers in the city were personally called upon and the story of George Williams was discussed with them. They listened attentively. A majority of them were sincere when they stated that they were interested in hiring George Williams in a junior capacity in their parts department. However, it was the time of the year when their volume of business was below normal. It was "spring break-up".

Starts Work

Two weeks later one of the first employers called telephoned the National Employment Office and said he was interested in interviewing Mr. Williams. That afternoon the special services officer accompanied George on his first interview. The following morning our applicant started work as a junior partsman. Our plan became a reality in its initial stages.

Five weeks later George's employer was visited. He said George was progressing satisfactorily and was well motivated. He had also overcome his nervousness which is not uncommon with applicants starting out in a new field of employment.

Four months later the employer disclosed that George was a most conscientious employee. He was progressing well in his work and was eager to gain a thorough knowledge of the company procedure in its parts department. Further reports on his progress during the year were complimentary.

On November 16, 1962, George Williams' employer telephoned the National Employment Office and placed an order for a junior partsman. George Williams was transferred to another city. The employer remarked with a smiling voice, "I have no objection to hiring a handicapped person".

Bernard McKenzie was born and educated in Prince George, B.C., and, following his graduation from high school, took a two-year Arts course in Vancouver. Later, he spent two years in Edmonton studying philosophy. He joined the Unemployment Insurance Commission in April, 1951 as an employment officer and was appointed special services officer in September, 1961.

HAPPY IN EMPLOYMENT THROUGH SPECIAL PLACEMENT SERVICE

by: Doris Charron, Special Placement Officer
National Employment Service

"I'm one of the lucky ones" said Patricia Jardine with a cheerful smile. "I have achieved independence, acquired confidence and experience and, because of my work, I am able to travel to all parts of the world during my vacation. I really enjoy it all very much."

Patricia Jardine, now 29 years of age, has been a cerebral palsy victim since birth. She attended the Montreal School for Crippled Children and completed junior matriculation at the High School for Girls. In addition, she took a course in typing and can type at moderate speed with accuracy.

Great Difficulty

Early in life Pat had great difficulty in standing without support and so was fitted with special shoes and, for quite a while, due to an unsteady gait, was obliged to walk with crutches. For a time she had great difficulty travelling on her own, but now has successfully overcome most of her problems in this respect.

She is the vice-president of one of the Cerebral Palsy Association's Recreation Groups, which is a club designed to provide a social outlet for men and women in their late teens and in their twenties afflicted with cerebral palsy.

"I look forward to our monthly meetings where we make fast friends, discuss mutual problems and learn what we can do to help others," Pat volunteered.

In June 1956, Pat applied to the National Employment Service, Special Services Section, Montreal, to obtain suitable clerical employment as she was in need of assistance and required help. She had applied for several jobs on her own without success. She was seeking employment counselling and, eventually, Selective Placement.

She was given several interviews and her ability was evaluated through a series of tests. She was found to be of average intelligence with fluency in French and verbal bilingualism.

She was first referred to a leading restaurant as a telephone order clerk but soon found out that she could not cope with the speed and the pressure involved in the work. Consequently, she returned to us to obtain another job.

As a second attempt, she was successfully referred as a clerk with a knowledge of typing. As the work required more speed than Pat could give she again became unemployed after three months and reported back to Special Services.

Work Entirely Satisfactory

During the "Employ the Handicapped Campaign of 1957", the Occupational Therapy and Rehabilitation Centre in Montreal received an order for a filing clerk. Patricia was selected and referred to fill the vacancy. She was employed for one year and three months and, while there, her work was entirely satisfactory. Due to a reduction in staff, however, she was once more out of work in August 1958.

I was able to place Miss Jardine as a mail sorter and inserter with several employers needing tem-

porary help for the balance of the summer.

In November, 1958 an interested employer, BP (Canada) Limited, Quebec Division, who had obtained a satisfactory employee through a previous referral of a handicapped person, requested the services, if possible, of another handicapped girl.

Patricia's qualifications, ability, experience, plus splendid work motivation, were discussed with this employer. This resulted in an invitation from the employer to visit his firm with our candidate in order to conduct a job analysis on the premises of the position in question.

The work consisted of filing documents and typing names of customers on file folders. She would be working directly under the section supervisor, a very sympathetic and understanding person.

It was agreed—as much of the work was performed while standing—that a desk and chair be placed next to the filing cabinet which would permit our candidate to support herself on the edge of the desk in order to help her to overcome muscular instability and to be able to sit if the work became too tiring at times.

Hired On Trial Basis

Our applicant was engaged at an interesting initial salary on a trial basis. Follow-ups with the personnel manager revealed that she was getting along fine and was absorbed on regular staff as a junior clerk, filing in the Records Section.

During her four years of steady employment she earned four merit salary adjustments and the employment supervisor stated she has not missed any normal salary increases through lack of ability to do her work. She is considered an employee with average ability.

Now she works alone from her own desk in the general office without supervision. She works steadily to keep her work up to date. She is interested in her work and has made suggestions denoting initiative that have been accepted. She gets along very well with her fellow-workers, is very happy and has gained confidence.

When asked by the employment supervisor if she would seek employment on her own if she should ever leave B.P., Patricia readily answered: "I would return to the Special Services Section of the National Employment Service for further help in securing employment. I was received with interest,

(Continued on Page 16)

CHAMBER OF COMMERCE AND THE EMPLOYMENT OF THE HANDICAPPED



Mr. Brown, who was born in Toronto, is an honours graduate of the University of Toronto, majoring in political science. He joined the Sun Life Assurance Company on graduation and is now Vice-President, Personnel. He has been an active member in a number of business and voluntary associations.

An original member of the National Advisory Committee on the Rehabilitation of the Disabled, he continues to represent the Chamber of Commerce on the National Advisory Council on Rehabilitation of Disabled Persons.

In the following statement, Mr. Graham Egerton Brown, vice-chairman of the Canadian Chamber of Commerce Executive Council, expresses the attitude of Canadian employers and businessmen in the employment of the handicapped.

"The Canadian Chamber of Commerce is persuaded that available evidence demonstrates that those employers who have had experience with physically-handicapped workers have found that their performance, when suitably placed, compares favourably with that of the able-bodied in similar work. The Chamber believes that their employment to the greatest extent possible is socially and economically desirable.

"The placing of the physically handicapped in suitable jobs is recognized as an essential function of the rehabilitation process. Indeed, without it much of the cost and effort expended in restoring the handicapped to a productive and self-sustaining place in society fails in its aim and an important source of employable manpower is not utilized.

"In line with the foregoing considerations, the Canadian Chamber of Commerce at its 33rd Annual Meeting, held in Vancouver in September, 1962 adopted the following declaration:

Employment of the Physically Handicapped

It is suggested that many jobs do not require the full capacities of an able-bodied person. If a handicapped person still has the required capabilities, he is not handicapped in that particular job.

Recommendations:

1. *That employers continue to co-operate in the placing of physically handicapped persons in suitable jobs; and*
2. *That employers who have not already done so investigate the possibility of employing physically handicapped persons."*

Canadian Diabetic Association Appoints Executive Director

The Canadian Diabetic Association recently announced the appointment of Mr. John Gillham as Executive Director. Mr. Gillham, who was born and educated in England, has had wide experience of organization and administration in Associa-

tion work both in England and in Canada. During the war he saw service in bomb disposal and later in prisoner-of-war camp administration. He served in administration and industrial relations for British Railways. In Canada he has worked in industry and public relations work and he is an experienced public speaker and writer.

ORGANIZED LABOUR SUPPORTS REHABILITATION

By A. Andras
Director of Legislation
Canadian Labour Congress

There is a great sense of satisfaction in being self-reliant. It is also part of the tradition of our country that men and women should earn their keep as long as that is possible. In more recent years, this tradition has been amplified and extended to recognize that there is a time when active participation in the working community should be replaced by honourable retirement. Similarly, it has come to be recognized that those who are not able to work through no fault of their own are still entitled to be furnished with the necessities of life. Accordingly, the aged and the unemployed in Canada can now look forward to at least a modicum of income when they are unproductive.

But there is one other group of people in the population who, if they are not able to work, find themselves in this position through no wish of their own. They are the men and the women who, because of mental or physical infirmity, cannot compete on an equal footing with their fellow citizens. There has been the feeling altogether too much and for too long, that people who do not conform to a preconceived standard of normalcy, whether mental or physical, should somehow be segregated and deprived of an opportunity of living a life as full as their remaining capacities permit. It is true, of course, that fine institutions have been established to help such people, but to a very great extent that help has been devoted to sustaining and sheltering them rather than giving them an opportunity to make use of the capacities still remaining to them. Fortunately, this situation is undergoing a major change. The emphasis is moving from support and custodial care, although these still are important, to rehabilitation and useful and remunerative employment.

Intrinsic Value of Work

Work is not only important as a means of livelihood. It has an intrinsic value. It provides a sense of self-respect and self-confidence. For the disabled,



Andy Andras is one of the representatives of organized labour on the National Advisory Council on the Rehabilitation of Disabled Persons. He came to Ottawa in 1940 as assistant editor of the official journal of the Canadian Brotherhood of Railroad, Transport and General Workers. Since that time he has done research work for organized labour and is the author of a number of labour handbooks. He has contributed many articles dealing with labour matters to national and international journals. Mr. Andras also serves on the Unemployment Insurance Committee and on a number of committees of the Canadian Welfare Council.

the opportunity to engage in gainful employment is both economically desirable and therapeutically valuable. That is why the growing movement towards rehabilitation of the disabled has become one of the most significant developments in Canada to date. It is significant because it is humane, because

(Continued on Page 17)

JOB PLACEMENT SERVICE FOR THE DEAF and HARD OF HEARING

By L. H. Parker

Executive Director

Canadian Hearing Society

Placement is the basic service offered by the Canadian Hearing Society. This service is open to those deaf persons whose health and abilities meet the necessary standards in business and industry. It is offered to hearing impaired post-school youngsters and to older persons without cost to the individual.

Definition and Philosophy

Who are the deaf? For educational purposes the deaf have been defined as "those in whom the sense of hearing is non-functional for the ordinary purposes in life". Almost all children who fit this definition require education in special classes or in schools for the deaf with specially trained teachers using special methods and equipment. Those who work intensively with the deaf understand that, by and large, the age of onset, the hearing level, the functional value of residual hearing with, or without, a hearing aid are all important in setting deaf persons aside from those who are only hard-of-hearing. This requires considerable interpretation to the layman.

The deaf are the same as hearing persons in more ways than they are different. Deaf persons are individuals with individual differences in their likes, dislikes and everything else that normally makes one person different from another. The mode of communication is probably the common element shared by deaf persons, along with the physical fact of profound deafness. Means of communication is by speech, lip-reading, sign language, the manual alphabet, writing or some combination of these.

It is generally accepted that vocationally competent deaf persons have established an enviable record in punctuality, application, lack of absenteeism, ability to attain a variety of skills, ability

to produce the norm expected and to "fit in" well.

Today, the record of the handicapped in industry and business is generally accepted in most of the enlightened countries of the world. The record of the deaf may not be as widely known as is the case of some of the other handicaps but, nevertheless, they are solidly entrenched. Tomorrow they will do even better as broader and improved facilities are available to them.

Notwithstanding this success, there are constant reminders that the deaf themselves must be continually alert to the dangers of a complacent attitude in an age that is trying desperately to reach a point where all people, regardless of age, sex, colour, creed, or circumstance, will have their proper place in society. In order to hold onto, and improve on, the gains made in industry and business, the deaf must recognize their responsibilities on and off the job. Both are extremely important. The deaf, just like everybody else, may enjoy the same privileges as anybody else. He is subject to the same laws, rules, regulations and acceptable behaviour patterns in the sight of all people. Being deaf does not excuse him from any of these. Today, it is part of the deaf man's life to expect the warmth of companionship, to be married, to have children, to have a good job, a car, a home with all the rest, and rightfully so, but he must recognize that, with his right to enjoy all of these privileges, there is the obligation to accept all of the responsibilities that go with, for the most part, unsupervised living to which he had not been accustomed in the past as part of residential school life.

The cases which come to our Society are varied. They include men, women and children of all ages and of different economic circumstances. Some of them learn of our work from friends or from their

business firms, others are recommended by public welfare organizations, schools, hospitals, the medical profession, homes or churches. Sometimes cases come from rehabilitation agencies because of a hearing impairment in addition to another disability. The Society co-operates to the full with all other agencies and organizations in the general field of rehabilitation.

Vocational Training

Schools for the deaf provide varied vocational subjects for its students. Courses vary according to the school but generally follow a close relationship. For the girls the following subjects may be provided: beauty culture, home economics, laundry work, sewing and dressmaking, typing and business machine operation. For boys the following subjects may be taught: carpentry, drafting, horticulture, metal trades which may include sheet metal work, machine shop and welding, printing, woodworking, upholstery and body and fender work.

In recent years selected brighter students have had the opportunity of reducing their vocational time and increasing their academic time to prepare for admission to Gallaudet College in Washington, D.C., the only college for the deaf in the world.

The majority of students graduate with vocational training and go directly from school into employment. It follows, therefore, that the majority of vocationally competent deaf persons will work with their hands. Some can be placed in occupations using the specific skills they have learned while at school and others are directed into a variety of jobs comparable to the capabilities of the individual.

Understanding Objectives

It is important to understand the objectives which the school endeavours to attain through its vocational subjects. The main objective is, of course, to teach skills but, as well, considerable emphasis is placed on good work habits, shop discipline, and group co-operation. A student who has been receptive to the program and works hard at it will succeed and make his own way in any job that is within his capabilities. If we have evidence that the subject is a worker, willing, co-operative, and has the ability to get along well with others, then the employer will do the rest. The record of the deaf in business and industry is the best illustration that can be given to demon-

strate the value of vocational subjects taught in schools for the deaf. Unfortunately, this fact is not brought home to the general public often enough, even to the moderately informed.

Retraining through provisions of the federal-provincial rehabilitation program serves a very useful purpose in cases requiring it. Thorough investigation, followed by careful assessment, is desirable to ensure successful rehabilitation. The best source for information is obviously the school which the applicant attended. The majority of cases, however, are best served by on-the-job training. In the past year two deaf students received financial assistance to attend university courses in the United States. Others have received training in hairdressing, welding, typing and filing.

No Preconceived Pattern

There is no preconceived pattern as to where the deaf will not fit. They are accepted and successfully employed in a variety of occupations heretofore reserved for hearing persons. They work as bakers, painters, carpenters, laboratory assistants, inspectors, copy typists, business machine operators, data processing technicians, office clerks, mail handlers, machinists, toolmakers, in drafting, sheet metal working, as printers, linotype operators, monotype operators, bindery operators, silk screen operators, artists, photo processing technicians, packers, textile operators, in varied government operations, as assistant librarians. They work in hospitals, institutions, restaurants, hotels, motels and in many other occupations too numerous to mention. Exceptional deaf persons have joined the ranks of the professions or established their own business enterprises. Now and again we like to mention the unusual. There is nothing unusual about operating an elevator even in one of the nation's leading first class hotels. It becomes unusual, however, when we hear of a man, born deaf, successfully competing with hearing people in this situation. It becomes the more unusual when we learn that he is a recent refugee from Europe and has the additional handicap of very limited English. The role of the employment officer in this case was simply to convince the employer of the capabilities of a man who happened to be deaf. The real success belongs to a supervisor who has an unusual gift in bringing out the best in a man who is willing and quick to learn, though deaf.

Some 10 years' ago, a 35-year-old man from the Maritimes came to our Toronto office looking for work. At an early age polio had left him deaf and partially paralysed down the right side. Neither arm could be raised above shoulder level, the right foot dragged a little, the fingers were knotted and not too flexible, making communication through writing or signs a very slow and difficult process. Nevertheless, despite all this he is the most cheerful, the most gentle man we have ever met. In spite of all these difficulties he had been trained to do many useful things. He could drive nails, use a saw, cut grass, shovel snow, even mix a batch of cement if need arose and many other useful things. The employment officer went through the book three times before landing a job — cleaning fruit in a large bakery, which he held until department changes forced his lay-off three years later. Faced with a long term of unemployment and being constantly termed "unemployable" wherever he went, he tearfully rejected welfare every time it was suggested, even when he was hungry. Like a true salesman he wouldn't give up and finally a job was found for him. For over four years now he has been working steadily, assisting the superintendent of a large convalescent hospital. His school training equipped him for many of the tasks he is called upon to perform. He is a respected employee and a well liked person.

Job Counselling and Placement

The employment officer is the key person in our organization. Trained staff working in this area must become familiar with the language, life and special problems of the deaf. Versatile, patient and dedicated, he is called upon to serve in many capacities. Experience will reveal to him the dearth of resources to meet special needs. Until such time as these gaps are filled he will continue to put existing facilities to the most advantageous use possible. His judgment in the various problems will grow out of experience.

The approach of the employment officer to management must be on a straight business basis. He must be fair to the employer to hold his confidence. He cannot recommend sub-par individuals to an employer and expect to retain his good will. There has always been a small segment of the deaf population considered unemployable due to factors other than deafness. The reasons are no different from those found in unemployable hearing persons.

Unfortunately, however, the deaf as a group are sometimes singled out as having the attributes of a deaf individual who falls far short of being a "leader in the community".

Those who work intensively with the deaf adult come to realize the importance of establishing the meaning of "responsibility" early in life. The wise parent will be consistent in demands on the child in this regard. With these roots the educator then has something on which to build to develop acceptable personality traits and good attitudes. This is an important part of the residential school program in which all staff members are vitally interested.

Parents, educators and the employment officer know no greater satisfaction, no greater prize, than the success story of a post-high school deaf youngster who has made good on the job.

In 1962, deaf and hard-of-hearing clients placed by the Society's employment officers earned \$539,840, based on the initial starting rate at the time of placement. During the same period the Society received approximately \$60,000 from grants and donations for its total operation.

(Continued from Page 11)

sympathy and understanding." She is convinced that some employers are still prejudiced about hiring a handicapped girl suffering from cerebral palsy and she would hesitate to seek employment on her own.

Patricia's case is one of many. Eager to work, possessing good intelligence, she attended classes, acquired skill and leads a normal social life. She loves her work and distinguishes herself in service to others hampered by cerebral palsy. She persevered to overcome her handicap and undertook remunerative employment. She serves as an outstanding example to many handicapped citizens.

What Patricia needed was suitable employment. The special services section was able to help her get it.

Doris Charron was born and educated in Ottawa. She was employed as a special investigator for the Montreal Police Department before enlisting in the RCAF (Women's Division) in 1941. She joined the Unemployment Insurance Commission at Montreal in 1946 and has been engaged in placement work since that time. In 1954 she was appointed Special Placement Officer.

Membership Increase

The International Society for Rehabilitation of the Disabled now has a total membership of 102 organizations in 55 countries.

CANADIAN HEARING SOCIETY

The Canadian Hearing Society was organized and incorporated under the Companies Act of Canada in March 1940. Its founders recognized the needs of the deaf and hard-of-hearing for a specialized agency to help them find their place in an increasingly complex industrial world.

The aim of the Society is to furnish a comprehensive specialized service for individuals of all ages, with impaired hearing, during the whole period of need. Rehabilitation of the hearing-impaired in all its phases is the concern of the Society with assistance and counselling based on the particular needs of the individual.

As distinct from rehabilitation in many fields, the term "rehabilitation", when used in connection with the effects of hearing loss, should be understood as a process starting with discovery in infancy and continuing through pre-school, elementary, and secondary school levels, culminating with special facilities for placement in employment on graduation. The term also denotes the procedures that may be necessary at any one of these levels or in teenage or adult groups.

The Canadian Hearing Society, with its head office at 2 Bloor St. E., Toronto, is under the able direction of Mr. L. H. Parker, familiarly known as Larry. Mr. Parker has a hearing impairment dating back to childhood. His hearing has been partially restored through micro surgery and he uses a hearing aid. Mr. Parker joined the Society as a placement officer in 1947, a position for which he was well equipped through a varied industrial background. He became Executive Director in October, 1960 and is giving outstanding leadership to an expanding program.

A regional office to serve Western Ontario was opened at 199 Queen's Avenue in London in 1961 and plans are almost completed for the opening of an office in Ottawa to serve Eastern Ontario.

(Continued from Page 13)

it is imaginative, and because it makes economic good sense. Rehabilitation and placement of the disabled person open up new horizons for him, give him an opportunity to use those physical and mental resources available to him and renders him a productive member of society.

Labour Recognizes Need

An important aspect of the movement for rehabilitation is that it cuts across society. It recognizes no class barriers. It brings together people and organizations from all walks of life. It is one in which the organized labour movement of Canada is committed to playing a useful role. The Canadian Labour Congress is proud of the fact that it is represented on the National Advisory Council on the Rehabilitation of Disabled Persons. Its affiliated trade unions and its provincial Federations of Labour have also been actively concerned with rehabilitation, more particularly as it applies to workers disabled by industrial accidents or diseases.

Basically, the organized labour movement recognizes that the relegation of disabled persons to custodial care when there is an opportunity for them to be active, even if only to a limited extent, is both inhuman and socially wasteful. Organized labour looks to the strengthening of the complex of activities which together can help to restore the disabled person to a useful life:—the skill of the physician, physiotherapist, the occupational therapist, the prosthetist, the social worker, the special placement officer; together with the laws which will provide financial resources to make their work effective; the sheltered work shops, the vocational schools, and other institutions. In addition to these, there is an important role for the employer who should find jobs in his establishment for the disabled worker and the trade union which should help him to adjust himself to a working environment and protect his economic interests as it protects those of other workers.

Organized labour is on the side of rehabilitation because it has always been a movement for social progress. It is glad to be in the ranks of those who are working to help the disabled in both their physical and economic restoration.

Mr. G. Roland Hennessey, Named Saskatchewan Provincial Coordinator

The Hon. A. M. Nicholson, Provincial Minister of Social Welfare and Rehabilitation in the Province of Saskatchewan, has announced the appointment of G. Roland Hennessey as Provincial Coordinator of Rehabilitation to succeed Dr. G. Allan Roeher. Dr. Roeher recently accepted the position of Executive Director of the Canadian Association for Retarded Children.

An Employer Speaks:

"DON'T UNDERSELL YOUR PRODUCT"

By Tom Moody

The following is a summary of a talk given by Mr. Moody during a discussion on placement of the handicapped in employment which took place at the International Great Plains Conference.

I am in the fortunate position of being able to speak to you from the point of view of an employer. We have been operating companies in Calgary and Edmonton for 14 years and we make it a definite policy to hire handicapped people in every capacity.

We now employ 19 physically-handicapped workers. Included are single and double amputees, as well as paraplegics. We do not care what their handicap is. We are concerned with whether they can work and earn their pay. Can they work an eight-hour day? They can and they do. They are the best employees we have.

A reference was made to a man who had very poor potential because he had only a grade four education. Let me tell you our experience. We had a man brought to us a few years ago who was in a similar position. He is now assistant manager of one of our branches. His salary is, I think, \$6,000 a year.

We had a man a paraplegic, with us for ten years. Later, after leaving our employ, he bought out the company he was operating and now employs six people and he spends his winters in Florida.

Another man came to us with practically no education. We had to send him to business college to learn to read and write. The principal of the college was so impressed with this man's courage in getting himself up and down the school stairs in his desire to get an education that he gave him his course free. This man stayed with us for twelve years during which time he became our assistant manager in Edmonton. He left us a month ago to go to British Columbia where he has bought a half interest in a business.

We have two other men, now in Vancouver who were trained in our Edmonton plant and who are doing very well.

We have many men in our organization who have severe disabilities. They are our hardest workers and the ones who are never at home with a common cold.



Tom Moody was born and educated in Montreal. He is the president and owner of three companies engaged principally in the electrical service industry. He has lived for the past 22 years in Calgary where he has served in many capacities on local service and civic groups.

Through his experience with handicapped people in northwest Europe during the war years, Mr. Moody developed an interest in the problems of the disabled which has carried over into his business. He makes a practice of employing handicapped persons and tries to interest other employers in doing likewise.

Where rehabilitation workers fall down is in selling their product. Not many people set out to buy life insurance. A salesman approaches a prospect and sells him on the benefits that come to him by purchasing life insurance. The same thing applies to placing handicapped people in employment. Place your people on the basis of the service they can render to the employer.

At breakfast I met a friend from army days who runs a soft water business in Calgary. He is thinking

of opening a branch in Edmonton. I asked him how many handicapped workers he employed. "None," he replied. "Why?" I asked. He said he had never thought of it. He has a big plant where they recharge zeolite softening mediums. I pointed out that there was no reason why handicapped people could not do this work. He agreed and said he would put two to work on the line. *He never thought of it* and no one had suggested it to him.

I am in sympathy with the problem of placement of the handicapped but I know that these people can be sold to employers and will give good value. The employer will lose nothing.

For instance you try to place a handicapped man in a bottling plant to inspect bottles to make sure there are no cigarette butts in them. This is a nice ordinary job for an ordinary worker. It requires a person to sit on the line and carry on a simple task. It is a job that can be done just as well by a handicapped man as an able bodied one. If you explain this to the employer you can't lose anything and in many cases you place your man.

The jobs we offer are mostly sit down mechanical assembly. Not everybody can do this but we use handicapped persons all the time.

I know of a distillery—a lovely place. They have people to put labels on bottles. Everyone of these workers is up and around yet this is a job that a disabled person could do. Here is an opportunity for a good selling job.

I am sure that if proper prospecting were done all kinds of handicapped people could be placed in jobs.

This is an area that interests me and in which I have some experience. I call a business man and say. "I know a man who is a good worker. He needs a job but he has a handicap and employers don't give him a chance. He doesn't want \$5,000 a year. Give him a reasonable salary and treat him like a human being and see what you get." You'd be surprised how often the answer is. "Well bring him aboard and we'll see what he can do." Three or four years later he's still there and doing an excellent job.

A good program of selling the worth of handicapped workers to employers is required. Just as in selling insurance you are offering an employer an opportunity which it is to his advantage to accept. But don't wait for him to come to you. He doesn't.

Books of Interest

The Province of Ontario—Its Welfare Services, 4th ed., Ontario Welfare Council, September 1962 110 pp. Price \$3.00

This is an up-to-date revision of what has become, since its first publication in 1954, a standard reference work in the field of social welfare. It is a useful and informative digest of Ontario Welfare Services providing ready access to information and details about the various services for health and welfare workers.

Better Health Care for Canadians, Publications Section, Canadian Welfare Council 22 pp. Price 50c.

This is a summary of the submissions of the Canadian Welfare Council to the Royal Commission on Health Services. It outlines the major findings and recommendations of the Council. It is intended for the use of board members, elected officials, health and welfare staff and study groups.

A multigraphed copy of the full brief, with the Summary, is also available. This is a 176 page document and sells for \$2.00.

Vocational and Technical Training for Girls in Canada, Women's Bureau, Department of Labour, pp. 96. Catalogue Number L38-1662 Queens Printer, Ottawa. Price 35c.

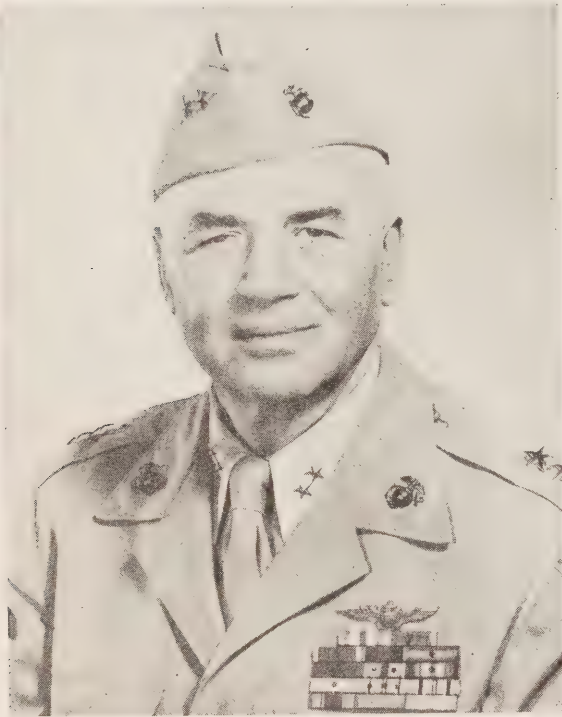
This booklet describes courses of vocational and technical training suitable for girls at the post high school, high school and trade school levels.

This type of information was assembled in an earlier edition last year but the supply was exhausted within a month. This expanded edition has been produced to meet a continuing need for this kind of information.

The booklet describes some of the fields of work open to women and lists the schools and other institutions in all parts of Canada that offer the appropriate training. It includes information about sources of financial assistance for education and training.

Nine broad areas of training are covered including art courses, business and commercial courses, training for health and hospital occupations, home economics courses, training as technicians, for skilled trades, teaching or service occupations. It includes possibilities in the three Services and other miscellaneous training opportunities.

PRESIDENT'S COMMITTEE ON EMPLOYMENT OF THE HANDICAPPED

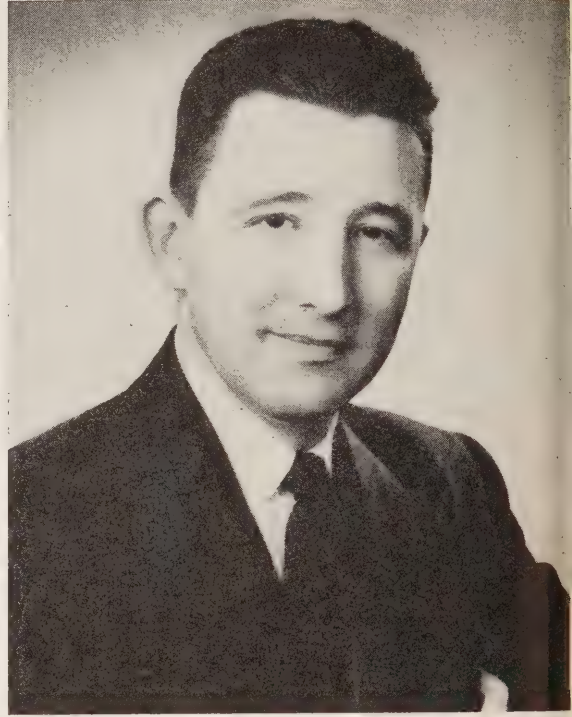


Major-General Melvin J. Maas is Chairman of the President's Committee on Employment of the Handicapped. He was first appointed in 1954 by President Eisenhower and re-appointed by President Kennedy on March 4, 1961. He is also Chairman Emeritus of the Committee for the Handicapped People to People Program.

A native of Minnesota, his career includes 16 years as a Congressman and service in the United States Marine Corps in three wars, during which he rose from the rank of private in Marine Aviation in 1917 to his present rank in August, 1952. He retired when blindness overtook him in 1951.

General Maas has received many honours and awards for his service in the Marine Corps and for his work with organizations concerned with the welfare of handicapped persons.

Fifteen years ago President Harry S. Truman penned a postscript to a routine White House letter, thereby sparking a social phenomenon which has changed the lives of some 4,000,000 Americans and benefited many millions more. His written suggestion to the Secretary of Labor that private citizens outside government be asked to spread a favorable climate of acceptance for handicapped job-seekers resulted in the formation of the President's Committee on Employment of the Handicapped, which last September celebrated its 15th anniversary.



William P. McCahill is Executive Secretary of the President's Committee on Employment of the Handicapped, Vice-Chairman of the Committee for the Handicapped People to People Program and Vice-Chairman of the Commission on Vocational Rehabilitation.

Mr. McCahill is a graduate of Marquette University College of Journalism. He served as a public relations officer in the United States Marine Corps from 1941 until he was appointed to his present post in 1947. He has received a number of awards both for his writings and for his services to veterans and others.

In 1947, separation centers and military hospitals were releasing many disabled veterans whose successful adjustment to civilian life was blocked by employer prejudice. Following production cutbacks, amputees and paraplegics were among the first laid off from shipyards and defense plants. There were strong doubts among personnel executives that "cripples" could compete effectively with the able-bodied in a peacetime economy. Some social thinkers, in desperation, were eyeing the experience of foreign countries where compulsory legal controls forced employers to hire a given quota of disabled workers.

Drive for Public Support

The President called for a volunteer program by public-spirited citizens to revolutionize the thinking of employers regarding qualified handicapped workers—to persuade business and industry to consider the abilities, not disabilities, of job applicants. Led by a retired admiral, Ross T. McIntire, who served without compensation, the Committee reached into all segments of public life to enlist the support of organizations and individuals representing 30,000,000 people to help spread the message that “It’s good business to hire the handicapped.”

Newspaper and magazine editors, theatre owners, public relations people, fraternal orders, unions, manufacturers, women’s clubs, religious groups, college presidents, medical societies, veterans organizations, and public officials all joined forces on behalf of furthering job opportunities for the handicapped. The National Association of Manufacturers and the United States Chamber of Commerce sat at the same conference table with the American Federation of Labor and the Congress of Industrial Organizations. Through the cooperation of the National Association of Broadcasters, millions of dollars worth of free radio and television time were donated to urge employers to give the handicapped a fair chance. The Advertising Council arranged for outdoor billboards to bring the message to the motoring public and the Post Office made the sides of thousands of trucks available.

After 15 years, there are dramatic results which contradict the early opinions of social psychologists that deep-seated prejudices and attitudes concerning the handicapped could not be reversed in less than a generation. Over 4,000,000 handicapped workers have been placed by the public employment service alone since the Committee began its informational and educational campaign. Just last year the Federal-State vocational rehabilitation program exceeded 100,000 successful rehabilitations for the first time in any 12 month period. Today, handicapped workers, when selectively placed according to their abilities, are proving themselves equal in every respect to their able-bodied co-workers, and some surveys have shown them out-distancing their fellow employees.

The Veterans Administration, which rehabilitated hundreds of thousands of disabled veterans of World War II and Korea, has released study

after study proving that “It is good business to hire the handicapped.” The Federal Government is a leading utilizer of the services of qualified handicapped workers.

National “Employ the Handicapped” Week

National Employ the Physically Handicapped Week, authorized by Congress and by Presidential Proclamation to be observed the first week in October to call special attention to the skills of handicapped workers, has now grown into a year-round program in every State and thousands of communities across the country where volunteer counterparts of the President’s Committee, under governors and mayors, work toward equal job opportunities for the handicapped. Recently, the President of the National Association of Manufacturers commented: “No program in the social field can show greater progress since World War II than this year-round effort to place qualified handicapped people in jobs for which they are fitted.”

In addition to the Employ the Handicapped Week project the Committee sponsors a yearly essay-writing contest among high school students of the nation and it has become one of the most popular programs. The Disabled American Veterans provide cash prizes for the top five prize winners. More recently the AFL-CIO, through state federations of labour, have been providing all-expenses-paid trips to Washington for state winners.

Special Projects

In 1954 the President’s Committee began holding regional meetings in various parts of the United States. These meetings bring together state and local leaders for discussion of common problems and achievements. Governor’s Committees are agreed that these meetings are a most potent force in maintaining a high level of rehabilitation services at the local level.

In 1956 an Advisory Council, made up of the heads of Federal Agencies concerned in a major way with rehabilitation and employment of the handicapped, was established. This council gives invaluable guidance to the President’s Committee.

In 1960, at the request of the President’s Committee, the President gave approval to the issuing of a stamp which carries the “Employ the Handicapped” message to the nation. This stamp was issued in conjunction with the Eighth World

Congress of the International Society for Rehabilitation of the Disabled and quickly became a "best seller".

Working in conjunction with the President's Committee is an Employer Committee made up of leading business executives from all parts of the country which has had marked success in encouraging businessmen to hire increasingly handicapped workers.

A Public Service Committee works to increase employment of handicapped in the government service. In the spring of 1957 the U.S. Civil Service Commission established a coordinator program. This calls upon each federal agency to appoint a coordinator to handle job placements of the handicapped. This program has grown in strength and effectiveness until there are to-day more than 3,500 coordinators on duty.

Building Standards Developed

The President's Committee joined with the National Society for Crippled Children and Adults to sponsor a project by the American Standards Association to develop an authoritative standard which, if adopted, would open wide buildings in the country to any handicapped person. This culminated in the publication of the American Standard Specifications for making buildings and facilities accessible to, and usable by, the physically handicapped.

With that began one of the latest campaigns of the President's Committee—to work for the adoption of the ASA Standard by communities all over the nation; to have the specifications written into

building codes; to interest architects and contractors and others in the essential need for the standard.

Reasoned the President's Committee: If a handicapped person cannot enter a building, how could he possibly work there? High flights of steps and other architectural barriers can deprive him of his right to equal opportunity for employment; can undo much of the work done over the years to broaden his horizons.

President Kennedy recognized the importance of the ASA building standard. He called it "one of the most promising developments on behalf of equality for the handicapped in many a year."

This committee was known originally as the President's Committee on National Employment of the Physically Handicapped. This name became shortened by common usage and Presidential approval was given to the President's Committee on Employment of the Physically Handicapped. In 1961 it was decided to drop the word "physically" since the needs of the mentally handicapped were becoming a matter of increasing concern and much of the activity of the committee was directed to the needs of this group.

Maj. Gen. Melvin J. Maas, USMCR Ret., Chairman of the Committee since 1954, says, "The Committee is proud to have been a working partner with the public and private agencies who have the operating responsibility in this area. We feel we have helped create a better climate of public acceptance for the qualified handicapped worker, whether physically or mentally handicapped. This has been, and must continue to be, a team effort."

Dr. B. W. Richards Given Visiting Professorship

The second visiting professor in mental retardation to be sponsored by the Ontario Association for Retarded Children, Dr. B. W. Richards, has taken up his post with the University of Toronto, succeeding Dr. L. T. Hilliard who has been in Toronto for a six month period. Dr. Richards comes to Canada with a great deal of experience in mental retardation, having been actively involved in this area since 1947. He is currently Deputy Medical Superintendent and Consultant Psychiatrist at St. Lawrence Hospital, Caterham, Surrey, England. While in Canada,

Dr. Richards will be working in close co-operation with the Toronto Psychiatric Hospital and the Department of Psychiatry at the University of Toronto.

Dr. Richards is editor of the *Journal of Mental Deficiency Research* and a member of the Editorial Committee of the *British Journal of Psychiatry* (formerly the *Journal of Mental Science*).

The OARC Visiting Professorship is a three year program to provide knowledge and information, as well as an opportunity for students to gain a greater understanding, of mental retardation and to encourage them to specialize in this field. (Canada's Mental Health, January 1963)

We are Proud of Our Handicapped Employees

*From "The Link", the news bulletin for the patients and staff
of St. Vincent Hospital, Ottawa, January 1963)*

St. Vincent hospital has, in recent years, become increasingly interested in the field of rehabilitation. It has developed new concepts and philosophy in relation to its responsibility to the person with a handicap. Emphasis is placed on the fact that employability depends on a worker's ability and not his disability. This hospital looks at the man's residual capabilities and judges him on these alone. If his capacities fit the minimum physical requirements to perform the job to the required standard, his other disabilities are not important. No special jobs are created for the disabled worker. The openings are filled after a selective placement has been made by the careful matching of the requirements of the hospital and the conditions of the work with the needs, circumstances and capacities of the individual.

In this institution, there are not less than 20 known disabled employees. Barriers of age and attitudes toward certain disabilities do not exist. They include amputees, blind persons, a deaf-mute ex-tubercular patient and people with hand or leg deformities of one kind or another. We also employ those who suffer from back and spine injuries, multiple sclerosis, epilepsy, poliomyelitis, nervousness, cardiovascular disorders and some with limited mobility.

Handicapped persons are actually carrying out with great satisfaction the following occupations: social work director, sub-contract supervisor, receptionist, dish-washer, laundryhand, refectory waitress, orderlies, kitchen help, elevator attendants, etc.

The employment of the physically handicapped in suitable jobs is not an act of charity. The disabled persons have been found to work effectively, are usually very conscientious and tend to care far more for their job than those who can seek work readily anywhere.

The return to suitable employment is part and parcel of rehabilitation. The authorities of St. Vincent have a responsibility to employ people with a handicap and they are taking up that responsibility with great pride.

SERVICES FOR OLDER WORKERS

There has been a tremendous upsurge of interest in recent years in the various problems connected with aging in Canada. One of these problems, and perhaps one of the more complex and difficult of solution, is the social and economic problem of the older worker. Most of the problems of aging concern mainly the 65-and-over age group, but the problem of the older worker reaches down to those in their forties and fifties and sometimes even younger.

Vigorous action has been taken in Canada for many years to reduce age discrimination in employment. The Canadian Department of Labour and the National Employment Service—through its vast network of local offices—each play a distinctive role in the measures taken. The activities of one complement the other so that, combined, they represent a powerful force working steadily on behalf of older workers. In addition, the federal government's Interdepartmental Committee on Older Workers, with representation from the NES, the Labour Department, the departments of National Health and Welfare and Veterans Affairs and the Civil Service Commission, acts in an advisory capacity. Considerable research has been carried out under the sponsorship of this committee.

The Department of Labour, through its Division on Older Workers, carries on a continuing educational program designed to create a more favourable employment climate for older workers and to discourage age discrimination. The division also co-ordinates departmental activities in the field; stimulates research and studies and watches developments in other countries. In addition, it accumulates and disseminates factual information on matters related directly or indirectly to older workers; answers enquiries; establishes and maintains liaison with national and provincial organizations; and generally serves as a central source of information in this field.

In the final analysis, however, substantial reduction of age-discriminatory practices and the removal of arbitrary age barriers in hiring, promotions and retention of workers, can only be brought about by co-operative action at the community level. To achieve such action requires the interest and co-operation of government agencies, em-

ployer and worker organizations and welfare and voluntary associations.

It is primarily at the community level that the National Employment Service, through its local offices, gives valuable service to older workers. Its local employment officers, with long experience of the problem, are regularly helping older employment applicants to secure suitable employment or, in some cases, training, to improve their chances of becoming re-employed. In their daily contacts with employers they try to persuade them to remove unnecessary age limits in hirings. Realizing the necessity of community co-operation they strive to bring this about.

The work of local employment officers on behalf of older workers has been helped by the wide distribution of a booklet, "How Old is Old?" published by the Head Office of the NES in Ottawa. The record of placements of older workers in recent years indicates that progress is being made in overcoming employer reluctance to hire workers past 40 years of age.

The Special Services Division of the NES, with some 350 special services officers across the country, offers special interviewing and counselling. These special services are available to employment applicants with physical handicaps and for young people, as well as for those whose primary difficulty is advancing age. Counselling services include an appraisal of the applicant's capabilities; assessment of his employment possibilities; aptitude tests when necessary; and understanding advice designed to raise the applicant's self-confidence and morale.

Frequently such services result in an applicant's being referred to a suitable job opening for which he is considered qualified; sometimes to special technical or vocational training courses; sometimes to the provincial rehabilitation co-ordinator's office or other agency for special services in connection with a physical, social or psychological handicap. In some cases, older persons who have been unemployed for long periods, have had their morale and self-confidence raised by good counselling to such an extent that they have gone out and obtained employment for themselves. Older applicants for employment are normally processed through the general placement services and placed in employment whenever possible. They are referred to Special Services when they present a special problem of placement.

The NES has placed a great many older ap-

plicants in suitable employment during the past few years. They can only achieve results, however, by the co-operation of employers. It is therefore in the interests of employers to list their job vacancies with NES to ensure for themselves a wider selection of applicants. At the same time job-seekers can help by co-operating fully with the NES and searching diligently on their own to find a job. Their chances of employment are increased when the efforts of the NES, on their behalf, are supplemented by their own earnest endeavours.

(Continued from Page 8)

employment office for placement have the potential ability to enter into competitive employment. The employment liaison officer reviews these cases and where it is clear that placement cannot be accomplished, he refers these back to the rehabilitation program for consideration of further training or other forms of rehabilitation.

Training-on-the-Job Arranged

Although suited to a particular job, some handicapped workers require further training-on-the-job before they can function effectively. When such a case and a suitable vacancy found, the placement officer refers it to the liaison officer who will arrange with the rehabilitation program to negotiate with the employer to obtain the necessary additional training by means of cost-sharing his wages while he is becoming a productive worker.

This was the case of Dale, a 21-year-old man who had been handicapped by defective vision since birth. Dale had received vocational training through the vocational rehabilitation program in radio and TV repair. However, although he was well-trained a suitable job in this occupation could not be located. In calling on employers the special service officer found a firm who wanted a motion picture projector repairman. The employer was willing to consider a handicapped applicant and was willing to train him on the job in the mechanical part of the repair work, but the applicant would need knowledge of amplifiers. With Dale's training in radio and TV, he had the necessary know-how about amplifiers and the job appeared very suitable for him. Through the liaison officer, this was referred to the rehabilitation program, officials of which negotiated with the employer for a short training on-the-job contract covering the experience needed for Dale to become a productive worker in this occupation.

Meeting a Special Need

There are times that the building of a ramp, widening of a washroom door or provision of a special chair is necessary to assist the disabled to take their place in employment. If these services are to be effective in the placement of the handicapped they must be made available immediately. This was just the situation we faced in finding a job for Andy. Andy was a paraplegic, confined to a wheel chair, who had been trained under the rehabilitation program in bookkeeping and office procedure. Many calls on employers had been made by the special services officers, in search of a suitable job for him. A job was finally found that appeared suitable, except the front steps to the office did not allow for a wheel chair to enter unless a ramp were constructed. The employer agreed to interview Andy for the job and, upon doing so, was ready to hire him if he could begin working Monday. This was Thursday and if Andy was to get the job a ramp was needed for Monday morning. The liaison officer contacted the Supervisor of Rehabilitation and discussed this immediate problem. The rehabilitation program was ready to provide the ramp and arrangements were made to have it constructed on the weekend. Monday, Andy started on his new job.

In conclusion, it must be recognized that the cases here mentioned have been those of the physically handicapped. Our work in special services deals, too, with employment problems of ex-prisoners, alcoholics, etc., and good liaison must be maintained with the organizations helping these people.

The responsibilities and duties of a liaison officer are not only to correlate the functions of the rehabilitation agencies but to give guidance and training to the special services officers in the entire field of special placements operations.

Robert MacCormack was born in Regina, Sask., and received his education in that city. He served in the RCAF as a Flying Officer during World War II. He joined the National Employment Service in 1946 and became a special services officer in 1955. He became Employment Liaison Officer for Saskatchewan in 1961.

Pan-Pacific Seminar on Vocational Rehabilitation of the Disabled

"Self-Respect Through Employment" was the theme of the Pan-Pacific Seminar on Vocational Rehabilitation of the Disabled held in Manila, the Philippines, during November 1962. The conference was sponsored by the World Com-

mission on Vocational Rehabilitation in co-operation with the Philippine Government and interested organizations. The objectives of the conference were:

1. To stress the ultimate aim of vocational rehabilitation, which is the employment of disabled persons in economically useful and productive positions;
2. To examine methods of preparation for employment of disabled persons through on-the-job training, special education and special vocational training centres;
3. To study the feasibility of pre-vocational programs for disabled persons;
4. To examine the role, functions, qualifications and training of vocational counsellors in the vocational rehabilitation setting;
5. To study practical methods in the development of work habits;
6. To examine existing national programs which are designed to stimulate community efforts in employment of the disabled;
7. To study means of utilizing existing international services for the development of local and national vocational rehabilitation programs.

Nations participating in the conference included Australia, Burma, Ceylon, Republic of China, Korea, Federation of Malaya, New Zealand, Pakistan, Hong Kong, India, Indonesia, Japan, Philippines, Thailand, The United States and Vietnam.

The keynote address was given by Dr. Aleksander Hulek, Rehabilitation Officer, Social Welfare Administration, United Nations. The International Society for Rehabilitation of the Disabled was represented by Mr. Donald V. Wilson, Secretary-General, who spoke on "The Role, Functions, Qualifications and Special Training of the Vocational Counsellor in the Vocational Rehabilitation Setting". Mr. John A. Nesbitt, Director of the World Commission on Vocational Rehabilitation, was in attendance. Participants in the program included Mr. P. J. Trevethan of Goodwill Industries in the United States, Mr. Paul Scher, Executive Director of the Governor's Committee on Employment of the Handicapped, from Illinois, and Mrs. Ester Peterson, Assistant Deputy of Labor, Department of Labor, USA, along with experts in the various aspects of rehabilitation from participating countries. Papers on "International Teamwork in Vocational Rehabilitation" were

presented by representatives of international bodies including the American Foundation for Overseas Blind, Asia Foundation, Co-operative for American Remittances Everywhere, International Labour Organization, World Health Organization, World Veterans Federation, United Nations Children's Fund, and the United Nations Technical Assistance Board.

Mr. Victor Baltazar, Supervisor, Office of Vocational Rehabilitation, S.W.A., Philippines, and a member of the World Commission on Vocational Rehabilitation shared with Mr. Ian Campbell, National Co-ordinator, Civilian Rehabilitation, Canada, the chairmanship of the planning committee. Mr. Campbell, Chairman of the World Commission, was unable to attend the conference itself and much of the success of the seminar was due to the outstanding leadership and dedicated service of Mr. Baltazar and Mr. Nesbitt.

J. P. Kennedy Jr. Foundation Honours Canadian Scientist

Dr. Murray L. Barr, of Belmont, Ontario, head of the microscopic anatomy department at the University of Western Ontario, London, was one of four scientists who received cash awards and trophies from the Joseph P. Kennedy, Jr., Foundation in December. The Foundation, established by President Kennedy's father in memory of a son killed during the Second World War, was begun to encourage research in the field of mental retardation. This is the first occasion on which such awards have been made from the Foundation but it is hoped it may become an annual event. Dr. Barr received \$8,333 for his own use and \$25,000 to use in furthering his research project.

Dr. Ivor Asbjorn Folling, of Oslo, Dr. Jerome Lejeune, University of Paris, and Joe Hin Tjio of Indonesia were the other scientists receiving awards.

The United States National Association for Retarded Children and Dr. Samuel A. Kirk of the University of Illinois were honoured also for their work on behalf of retarded children. The presentations were made by President Kennedy.

Access Ramp Approved

A recommendation that an access ramp be constructed at Saskatoon City Hall has been approved by the City.

People and Events

National Coordinator Receives Citation in The United States

Ian Campbell, of Ottawa, the National Coordinator, Civilian Rehabilitation, Department of Labour, and Chairman of the World Commission on Vocational Rehabilitation of the International Society for Rehabilitation of the Disabled, was the recipient of a citation from the American People to People Program for his "leadership in emphasizing the importance of job-oriented rehabilitation efforts around the world."

The award was presented to Mr. Campbell, at the International Luncheon of the National Rehabilitation Association in Detroit, by William McCahill, vice-chairman of the People to People Committee for the Handicapped, and executive secretary of the President's Committee on Employment of the Handicapped.

The People to People Program was established by President Eisenhower to promote international friendship between individuals and nations.

Mr. Campbell was appointed National Coordinator of Civilian Rehabilitation in 1952 when Canada's federal-provincial rehabilitation program was in its early stages.

Prior to that time he had served with the Women's Compensation Board of Ontario from 1937 to 1951, first as Chief Rehabilitation Officer and then as Superintendent of the Board's rehabilitation activities. He was also Chairman of the Ontario Old Age Pension Commission in 1950.

Fifth Inter-American Conference on Rehabilitation

Mexico City was chosen as the site of the fifth Inter-American Conference on Rehabilitation sponsored by the International Society for Rehabilitation of the Disabled. The conference was held in conjunction with the fourth National Congress for the Rehabilitation of the Physically Disabled at the Medical Centre.

In attendance were not only medical personnel but representatives of labour and management.

Hall H. Popham, of Ottawa, President of the International Society, spoke on the program of the International Society and its aim to make it possible, through a world-wide network of voluntary organizations, for every disabled person to remove

to reduce his impairment with the help of medical, social, educational and vocational services so that he might assume his rightful place in the community.

Dr. Conrad Zuckerman, Under-Secretary of Health and Welfare in Mexico, noted that it is not enough to keep a man from dying. He must be enabled to take his rightful place in the world of work and assume his rights and responsibilities of citizenship. This is a new concept in Mexico where it has previously been the custom for society to take care of disabled persons. Now, society endeavours to train the disabled individual to care for himself.

Dr. Aleksander Hulek to United Nations Post

Aleksander Hulek, M.A., Ph.D., has been appointed Officer-in-Charge, Rehabilitation, in the Bureau of Social Affairs, United Nations. Dr. Hulek is from Poland, where he was Chief of the Section for Vocational Rehabilitation in the Ministry of Health and Social Affairs. He also served as General Secretary of the Polish Society for Rehabilitation. He succeeded Mr. Seiji Taksumoto of Japan in the United Nations Post.

Newfoundland Coordinator Undertakes Challenging Assignment

The many friends of Walter H. Davis, Provincial Coordinator of Rehabilitation in Newfoundland, will be interested to learn that he has agreed to undertake the formation of the National Association for the Advancement of Canadian Rehabilitation. Mr. Davis is well qualified to accept this challenging work. In order to devote his full time and energy to the task before him, Mr. Davis is asked to be relieved of all other responsibilities.

A Newfoundlander, Mr. Davis has been Coordinator of Rehabilitation since 1954 and Executive Secretary of the Newfoundland Tuberculosis Association since 1946. Prior to that he was a member of the teaching profession, having been principal of a number of schools in the province. He is a graduate of Memorial University and continued his studies in both Acadia and Columbia Universities. With a deep interest in health and public welfare, he is well known throughout Newfoundland as a lecturer on health education and rehabilitation.

Mr. Davis is active in a number of organizations including the Rotary Club, the Newfoundland Safety Council, the Safety League of Canada and the Boy Scouts Association. He is president of the Home and School Association of Prince of Wales College.

As Coordinator, Mr. Davis provided outstanding leadership for an expanded program of rehabilitation and the development of a system of case finding unique in Canada. We extend best wishes to him for success in his new undertaking.

Dr. James Wallace Graham

All people working in rehabilitation will be sorry to hear of the death on December 14 of Dr. James Wallace Graham M.D., F.R.C.P.(C), F.R.C.P. (Lond.). Dr. Graham was the first president of the Canadian Arthritis and Rheumatism Society and long-time chairman of its Medical Advisory Board.

During the war he served in a clinic which brought together all the arthritic patients from the three Services and which was the forerunner of the arthritis service at Sunnybrook Hospital. Much research into arthritis was initiated there and many training programs carried out.

Dr. Graham returned from his war service convinced that much more could be done to bring the benefits of recent knowledge and experience to the civilian population. Much of his life was devoted to the furthering of projects developed to this end. In addition to research and expanded treatment facilities, he saw a need for the training of personnel to work in the field of rheumatology. He was a teacher of note and most medical personnel at present engaged in this field in Canada have at some time come under his influence and instruction.

The Canadian Arthritis and Rheumatism Society have established in his memory a fund to be known as the Wallace Graham Memorial Fund. A committee has been set up to recommend a suitable continuing memorial project.

Pippy Awards Presented

The opening of the 1962 Christmas Seal Campaign in Newfoundland was marked by the presentation of the Mr. and Mrs. C. A. Pippy awards to "The Handicapped Man and Woman of the Year."

Receiving the awards this year were Dorothy Letto, of Forteau, Labrador, and William Lane, of St. John's, Newfoundland. These awards, which were made for the first time in 1961, consist of \$500 and a plaque donated by the Newfoundland Rehabilitation Council. They are presented to the handicapped man and woman who show the greatest fortitude in overcoming their disabilities. The presentation was made by Mrs. Campbell Macpherson, wife of the Lieutenant-Governor of the Province.

Miss Letto, recipient of the woman's award, contracted polio at the age of six and spent 28 years in and out of hospital undergoing the medical and surgical treatment required to get her out of her wheel chair and to the point where she can get about and climb stairs with her crutches. In 1959 she went back to school to obtain her grade ten diploma and be accepted for a commercial course which she completed successfully. She is employed now as a clerk-typist at the Grenfell Hospital at St. Anthony.

The other recipient, William Lane, was 22 and working as a watch repairman when he was stricken by arthritis. He was confined to hospital for eight years and spent another seven learning to walk again with crutches after he was fitted with metal joints when other methods failed. In 1951 he started his own watch repair business, working in a standing position at a high bench. In 1954 he devised and installed hand controls in his car to enable him to drive to night school. In two years he completed grades nine, ten and eleven with honours and then entered Memorial University to begin a pre-medical course.

To finance his education, Bill worked during his vacation and took a year off from his studies, during which time he acted as a rehabilitation officer with the Department of Health. Incidentally, it was from Bill Lane that Miss Letto learned of the opportunities available for handicapped persons to receive training which started her on her way to independence.

In spite of a bout in hospital for surgery for an ulcer, Bill graduated with a Bachelor of Science degree in 1961. Since that time he has been employed as a mathematics instructor in the Vocational Training Institute. He plans to continue his studies doing post-graduate work in biology.

Awards Presented to Saskatchewan Employers

For the second time, Lieutenant-Governor Frank Bastedo of Saskatchewan has presented awards to employers with outstanding records in the employment of handicapped persons.

Receiving citations were B. Lilley Drapers and Western Clay Products, both of Regina, and Canadian Pittsburg Limited of Moose Jaw. The presentations took place during the annual congress of the Council on Rehabilitation (Saskatchewan) held in Regina.

Polio Victim Wins Scout Badge

Stricken with polio since he was seven, Lionel Hope, 17, of Peterborough, Ontario, recently became the first Peterborough Scout confined to a wheel chair to gain his First Class Scout's badge.

Lionel, a member of St. Paul's Troop since 1957, has carried out every Scout test satisfactorily without special allowances being made for his disability. Another handicapped Scout, Brian Fayle, recently completed his Second Class test with St. Paul's Troop.

(From *The Phoenix*)

Rehabilitation Offices In Canada

NATIONAL OFFICE

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OTTAWA, Ontario.

PROVINCIAL OFFICES

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Department of Health,
Post Office Box 5250,
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Provincial Rehabilitation Co-ordinator,
Department of Public Health,
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Director and Co-ordinator of Rehabilitation,
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FREDERICTON, New Brunswick.

Physically Handicapped Division,
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Provincial Co-ordinator of Vocational Rehabilitation,
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Provincial Co-ordinator of Rehabilitation Services,
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Kennedy & York,
WINNIPEG 1, Manitoba.

Provincial Co-ordinator of Rehabilitation,
Health and Welfare Building,
REGINA, Saskatchewan.

Provincial Co-ordinator of Rehabilitation,
Department of Public Welfare,
109th Street and 98th Avenue,
EDMONTON, Alberta.

Rehabilitation Co-ordinator,
Department of Health Service and Hospital Insurance,
828 West 10th Avenue,
VANCOUVER 9, British Columbia.

UMMER

1963



Rehabilitation **IN CANADA**



Published in the interests of Canada's Disabled by ...

CIVILIAN REHABILITATION

Department of Labour Canada

"There is no distinction that can properly be drawn between the hospital services provided for the 'disabled' and those provided for patients generally. Indeed, the primary objective of the hospital services is to treat the patient so as to leave no further problem of training or resettlement; and although the actual numbers of those who continue to suffer from some permanent disability are considerable, they represent only a small proportion of those discharged from hospital treatment. In the widest sense, therefore, all the normal diagnostic and treatment facilities at hospitals and clinics can properly be described as rehabilitation services, particularly where they are so organized and directed by the medical staff that restoration of function to the fullest possible extent is kept in mind by all concerned from the patient's first consultation or admission until his discharge."

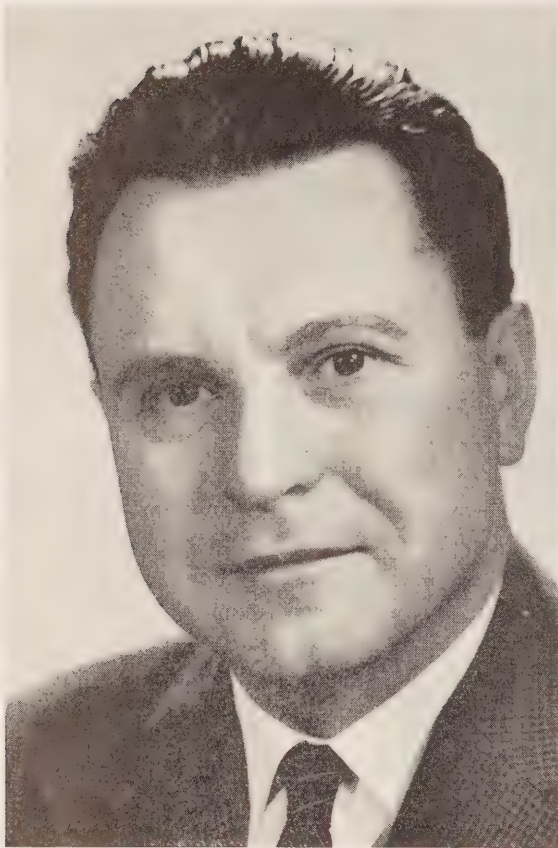
Piercey Report (Great Britain)

C O N T E N T S

Page

- 4 An Approach to the Problems of Physical Rehabilitation
- 7 Physical Methods in General Medical Practice
- 10 Medical Rehabilitation in Windsor
- 12 Communication and Vocational Rehabilitation of the Disabled
- 13 Rehabilitation—Concept and Practice
- 16 The Need for Medical Rehabilitation—Experience in Alberta
- 18 Electronic Control of Paralysed Limbs
- 22 People and Events

This bulletin is prepared by Civilian Rehabilitation, Department of Labour, with the co-operation of the Department of National Health and Welfare, the Department of Veterans Affairs, the National Employment Service and governmental and private agencies interested in the rehabilitation of Canada's disabled.



I am pleased that this issue of *Rehabilitation in Canada*—the first with which I have been associated as Minister of Labour—has the emphasis in content on the medical aspects of rehabilitation. This is an area in which my Department and the Department of National Health and Welfare work closely together.

In extending my greetings to you who are engaged in helping Canada's disabled develop a life of usefulness and fulfillment, it is an added pleasure to know that they are coupled with those of my colleague, the Honourable Judy LaMarsh, Minister of National Health and Welfare.

A spirit of co-operation exists between our two Departments in the administration of the Vocational Rehabilitation of Disabled Persons Act. This same spirit and teamwork extends to the National Employment Service and the Department of Veterans Affairs and to the provinces and voluntary agencies which are engaged in the development of facilities and services for disabled Canadians.

As long as we all work toward the common objective and continue close collaboration, we can look forward to continued expansion of the federal-provincial vocational rehabilitation program to benefit Canadians in all walks of life who suffer, or have suffered, from disability.

ALLAN J. MacEACHEN
Minister of Labour



This issue of *Rehabilitation in Canada*, stressing as it does the medical aspects of the subject, is of particular interest to my Department. I am pleased to be associated with my colleague, the Honourable Allan J. MacEachen, in taking the opportunity to offer to extend greetings to all those working on behalf of disabled Canadians.

The objectives of medical rehabilitation are clearly defined but the course to be followed in achieving these objectives is less so. In charting and pursuing that course, a high quality of teamwork is demanded to fully utilize the variety of disciplines and resources employed. Such co-operation has been achieved in considerable measure, and this has certainly been a major purpose of our two Departments.

Workers in the field of rehabilitation are faced with a continuing challenge. Many of the consequences of disability are preventable. There is a wide range to the active role the handicapped citizen may enjoy through the processes of restoration. The Department of National Health and Welfare is taking a substantial part in the development of these processes through the Hospital Insurance and National Health Grants programs.

My Department is vitally interested in the Vocational Rehabilitation of Disabled Persons program and will co-operate in every way to assure its success.

JUDY LaMARSH
Minister of National Health and Welfare

To Our Readers

THE NATURE AND ROLE of restorative services in the rehabilitation of disabled persons is the theme of this issue of the bulletin. We gratefully acknowledge the contribution of the medical specialists whose articles cover the broad spectrum of services required to eliminate or reduce disability.

The trend, internationally, is to develop medical restoration services as an essential and integral part of health care, to establish adequate means of early identification of those who will have permanent disability, to refer such people to vocational rehabilitation and to provide continuous consultation to such service.

In Canada the influence of medical rehabilitation should stimulate constructive planning of convalescence and home care and reach out into institutions for custodial care. For those who will have a handicapping condition additional services will be required to effect their social and vocational re-establishment. Those services must be co-ordinated with the medical services so that all working together can help the handicapped to their goal—a job enabling the individual to be independent and able to take his rightful place in the home and community.

A vocational rehabilitation program utilizes many services and disciplines but to be successful it must be founded upon a well rounded program of health services firmly based upon the principles of rehabilitation medicine.

AN APPROACH TO THE PROBLEMS OF PHYSICAL REHABILITATION

By DR. A. T. JOUSSE, Superintendent, Lyndhurst Lodge.

(Dr. Jousse was one of the speakers at the Ontario County Rehabilitation Conference at Oshawa in March. As space does not permit us to reproduce his talk in its entirety, the following is a condensed version.)

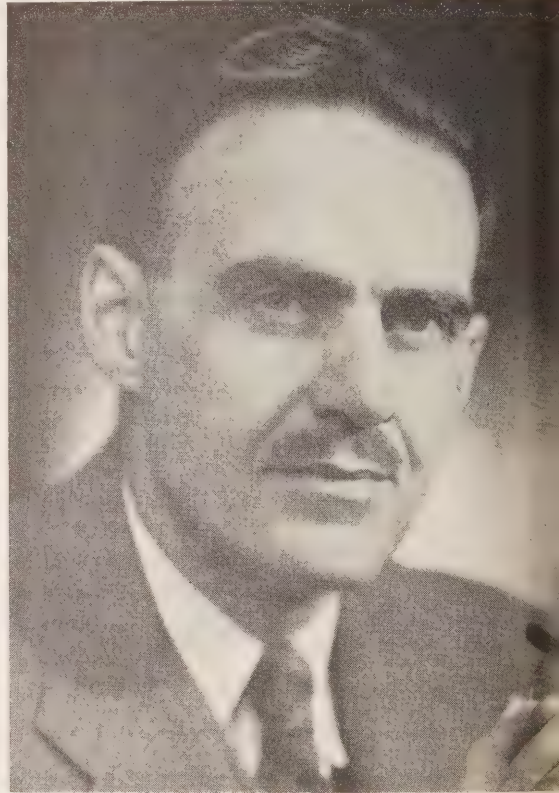
Rehabilitation is a term which has come into common usage during the past few years, but, simply stated, rehabilitation means doing what must be done to restore the function for which a certain entity was designed.

My concern is with the rehabilitation of people who are prevented from functioning successfully as human beings by virtue of disease processes or injury which has resulted in impairment of physical function—the so-called physically disabled. They are readily identified and respond, by and large, to a certain formula or program of treatment.

The Need for Rehabilitation

Let us first consider why the need for rehabilitation has become so pressing at this stage in our social development in the western world. The preservation and resulting prolongation of life which has resulted from the mastery of acute and fatal disease as achieved in this century; the improved well-being which has accrued due to public health measures; the improved nutritional standards deriving from higher income and greater availability of food and shelter; the preservation of life in the face of serious and heretofore fatal accidents; the prevention of wound infection have all contributed to the survival of persons, many of whom remain seriously disabled and many more of whom are of advanced years.

The accumulation of these persons who are unable to achieve personal and economic independence, yet who are of necessity consumers of goods and services, has come to constitute an economic threat to society. This problem has always been with us—but it is now of greater magnitude than formerly.



Dr. Jousse is a Certified Specialist in Physical Medicine and Rehabilitation, Medical Director of Lyndhurst Lodge Hospital, Director and Associate Professor, Division of Rehabilitation Medicine, Faculty of Medicine, University of Toronto.

He is also a consultant at Sunnybrook Hospital and is a Council Member of the International Medical Society of Paraplegia.

Growing Opportunities

Fortunately, the technical skill of our engineering friends has diminished the emphasis on physical fitness and brawn as a requisite for doing a given job, and has substituted the requirement of a skilled performance on the part of only a small segment of the body. This permits the disabled to work productively. So, while advances in the realm of medicine of this century have

created a problem by making possible the survival of many unfit and disabled people, at the same time the technical advances within our society have made it possible for the unfit and maimed, in a great many instances, to be integrated into the processes of industry and into the service occupations if we but have the patience, skill and good-will to work out the details.

A Plan of Management

There is a formula or a plan of management which, if followed, will successfully restore disabled people to useful living. It is very simple of concept, though sometimes difficult of execution. It does not always work, nor is this special care and management necessary in all cases. Nevertheless we know from experience that a fairly large group succeeds with help and fails without help.

Diagnosis—The first requirement is *diagnosis*. This is the sine qua non of proper management. At first sight one might consider this to be self-evident. However, there is a tendency amongst enthusiasts, particularly lay enthusiasts, to say in effect, "Let's not bother with the puck—let's get on with the game". In certain quarters I have met resistance to the idea that a physician or surgeon must first see the patient and establish, as far as possible, the exact cause of the disorder. This is particularly likely to happen when dealing with persons whose disabilities have been of long standing. It must never be allowed to take place.

Therapy—Precise diagnosis makes possible the second part of the formula, which is specific or palliative therapy applied to the management of the disease or injury.

When the therapy has been instituted and the desired results achieved, or at least approximated, the third measure may then be applied. This, too, is a responsibility of the physician or surgeon, although he may require assistance from various other professional people.

Evaluation—This third step is that of *evaluation*, i.e., evaluation of the deficit or impairment from which the patient suffers. Evaluation is the key to restorative management of the person who is disabled. It consists not only of defining the

persisting disability in terms of structure and dysfunction, but must as well include an interpretation of the dysfunction to the patient, his family and friends and possible employer. Thus, it must include a statement as to what the patient may and may not do.

By way of example, I would like to point out that physical disability usually manifests itself in one of three areas of performance or of impairment.

Categories of Impairment—The first—impairment of locomotion; the second—impairment of skilled activities of the upper extremities whereby we practice the skills of the mind, and the third—impairment of communication. It is obvious that loss or paralysis of one or both legs, or swollen or painful joints of the lower extremities will lead to impairment of locomotion. Not so obvious, perhaps, is the impairment of locomotion resulting from diseases of the heart or lungs, or from obesity. The handicap resulting from loss of locomotion requires little elaboration. Such a person is hindered in almost every one of life's activities.

The management, of course, consists of restoring locomotion—by teaching the patient to walk with artificial limb or braces and crutches, or by making him mobile in a wheelchair.

Actually, it is fairly easy to compensate for impairment in this area.

A much more difficult problem is that posed by the man or woman who has suffered loss or impairment of his upper extremities. Whether this be due to amputation, paralysis or joint disease, is immaterial. What is important is that the skills of the mind—which are practiced or executed through the use of the hands—provide the source of our livelihood—whether we be surgeons, stenographers, tool and die makers or housewives. To circumvent or substitute for such impairment is not easy. Yet to render such a person economically and socially independent it is essential that the hurdle be overcome. The very elemental activities of daily living, whereby we dress and undress, and groom ourselves, are prerequisites to life out of an institution. Yet with the best technical help in the world our efforts to overcome this type of deficit fall far short of the ideal.

The most serious difficulty of all is that which results in impairment of communication. This type of impairment most commonly occurs in connection with strokes, where there is a primary deficiency of speech production. To a lesser extent it occurs in association with impaired function of the upper extremities where writing is impaired and, of course, in cases of loss of sight and hearing. Although much effort has been devoted to compensating for, and circumventing, disorders of communication, our achievements in this area are even less effective than in the preceding two categories described.

On reflection it will be perceived that the common physical disorders produce impairment in one or two or all three of the three categories described.

However, evaluation must extend beyond a simple noting of the deficit and resulting impairment. There is a tendency to become pre-occupied with the patient's disability. Of much more importance are his remaining assets. We must know of his achievements at school, at work, at play. We must know his family background, for blood is important in humans as well as in horses. His age cannot be disregarded.

We usually assess intelligence by clinical examination and by psychological testing. This requires the aid of a psychologist. Good intelligence, like good physique, is an important asset. When combined with motivation and drive it is the key to successful endeavour. Achievement in school provides a very excellent assessment of both factors. Grade 8 at 12 years or 13 years and Grade 13 at 17 years or 18 years indicates a boy or girl of good intelligence and good motivation.

Restoration— Having completed evaluation—how does one restore useful function? Well, it is very much like training for a team. Where age and general health permit, we restore well-being through exercise—through a program of calisthenics—often in a gymnasium. Disabled persons respond to exercise as do the physically normal, provided they are not suffering from active infection or progressive degenerative disease. Using the technique of the weight-lifters we often apply resisted exercises to weak muscles and they become strengthened. Having restored well-being and strength through activity supervised by therapists, we teach skills—the skill of walking, of

writing, of dressing and undressing, of speaking. The doctors are assisted by nurses, physical and occupational therapists, physical training instructors and speech therapists.

This strenuous and often prolonged course of training is hard work. Most of us work only for a reward—the satisfaction of pleasurable work—of achievement—of recognition—of a place in society—of which money is a yardstick—but not too often a goal in itself.

Achieving a Goal

For the disabled the goals are the same and the rewards are the same—but the road is more difficult. Yet many disabled persons will follow this difficult road—but only if the goal is made attractive and the goal is presented in a realistic fashion. The secret of rehabilitation of disabled persons is not legislation to force industry to employ the handicapped. Rather, it is to so educate and train the disabled and then find for them a vocation in which their disability does not constitute a handicap. Indeed, the well-placed person with a disability is as productive as he would have been if he had not become disabled. The training or education of the disabled is the responsibility of the educators, and they do superbly well. They should be brought in more closely to the rehabilitation team, however.

In actual fact the majority of people are able to cope with physical disability with the aid of their doctors, their families, their friends, and the social institutions such as schools or churches which exist in our society. However, where the disability is severe and the resources of the individual or his community are not quite up to the mark, a special effort must be put forth by all concerned in order to achieve a successful climax—best done in one's own community.

The needs of disabled persons are not, then, essentially different to those of the non-disabled. Their illnesses and disabilities require treatment and management—they must be educated and advised—they must be kept within the fellowship of society and not be made to feel that they are strikingly different or bizarre. When dealing with children, the greatest asset is, of course, wise and

(Continued on Page 23)

PHYSICAL METHODS IN GENERAL MEDICAL PRACTICE

By BROCK M. FAHRNI, M.D., F.R.C.P.(C), Director,
School of Rehabilitation Medicine, University of British Columbia.

The tremendous contributions of the bio-chemist to medicine in the past few decades (such as the preparation of vitamins, antibiotics, hormones, sedatives and anti-inflammatory agents) has led to a certain preoccupation on the part of the profession with these valuable new chemical agents in treatment. Yet in the same period since the war, much more scientific medical evidence than ever existed previously has been produced to prove the value of physical measures. Every doctor, of course, makes use of both types of therapy but not all take as full advantage as they might of the benefits which can result from the routine consideration of physical principles in practice. The purpose of this paper is not to show that one mode of treatment is better than another, but to point out that optimal treatment of regular medical and surgical conditions in general medical practice cannot be obtained without the early and judicious use of what has come to be known as physical medical methods, and that such treatment is not to be reserved only for the rehabilitation of more severe disabilities.

Place for Physical Methods

For example, rheumatoid arthritis is a condition which can be treated in several ways. In many clinics and private offices in this country and the U.S.A., the approach is almost entirely chemical (that is, drug therapy alone). We know that the course of the disease can be greatly modified and the end result much better if suitable physical measures are utilized. I refer to (a) the proper rest and immobilization of the joint in the actively inflamed stage through proper support of the part, keeping the strain off the joint capsule and ligaments and lessening muscle spasm (which otherwise exerts pressure on inflamed joint surfaces and inflamed synovia) through the employment of suitable resting splints



Dr. Fahrni graduated from the Faculty of Medicine at the University of Manitoba and practiced in Vancouver until he joined the RCAMC in 1940. After five years service he returned to Vancouver where he specialized in internal medicine. He joined the staff of the Faculty of Medicine at the University of British Columbia in 1960, where he is Director of the School of Rehabilitation Medicine. He is Chairman, Chronic Care and Rehabilitation Committee of the B.C. division of the Canadian Medical Association and advisor in Chronic Care and Rehabilitation to B.C. Hospital Insurance Commission.

He is interested in the development of community rehabilitative services, in particular the Canadian Arthritis and Rheumatism Society and the Assessment and Rehabilitation Unit at Shaughnessy Hospital where he is a director.

Dr. Fahrni is a member of the National Advisory Council on Rehabilitation of the Disabled.

or plasters. This also relieves pain and prevents fatigue of the patient through sleeplessness, etc; (b) Proper passive range of movement exercises which prevent adhesion formation and restriction of joint movement, and which are possible to carry out from the onset with removable casts.

Instruction in muscle-tensing exercises also applies here; (c) Active exercises, when the inflammation has sufficiently subsided, to preserve movement, recondition the joint, and build up the muscles which give the normal support for the joint and for normal use. These physical measures have been known and used for many years in certain centres, but only since the war have so proved themselves as to have become known as "the basic program" in the treatment of this disease, with other forms of drug therapy as adjuncts. This is not to say that analgesic drugs and occasionally anti-inflammatory hormones may not be of great assistance in controlling the acute inflammation and permit earlier active physical treatment to take place. Also, there are other forms of arthritis such as gout where the control is primarily chemical.

Increasing Awareness of Value of Physical Methods

Stroke programs, both in the initial hospital phase and later continuing care, rely almost entirely on physical medicine procedures. In fractures, sprains and traumatic surgical conditions, physical medicine may be essential to guarantee full recovery. Many conditions, for which the patient sees the doctor in everyday medical practice, are related to the presence of muscle tension or muscle spasm. Increased tension of bowel muscle may cause upper, mid, or lower abdominal pains or sometimes chest pains; tension in bronchial muscle may give asthmatic symptoms; tension in the muscles of the diaphragm may be associated with the above asthmatic symptoms or other situations associated with shortness of breath, lower chest pain, fatigue and faintness, etc. Stiff neck and lumbago from increased tension of para-spinal muscles are also well known in regular practice. These are but a few examples of common day-to-day conditions which, in the main, are treated with drugs alone when instruction in suitable exercises and muscular relaxation by a trained therapist may be all that is required. Certainly the latter prescription may constitute an important part of the treatment program and is too often ignored. Referral of postural problems to the therapist constitutes good preventative medicine.

Safety of Physical Methods

One other factor which favours the use of physical methods over drugs is the fact that the former when applied by a trained therapist, for no matter how long a period or how often, is a completely safe procedure. Many drugs have serious side effects which may occasionally threaten the health or life of the patient, particularly if they have to be used repeatedly in the care of chronic diseases. We have come to believe that the use of a marrow-toxic drug or steroid hormone like Cortisone for the relief of muscular or ligamentous pain in a condition which would respond equally well to simple physical methods constitutes poor medical management.

Changing Trends in Therapy

In this past decade particularly, there has been a swing away from passive modes of therapy in the direction of active exercise. These exercises must be specially selected for each patient's case and must be thoroughly taught to the patient with more or less exact instructions in how to use them if good results are to be obtained. It is recognized that using the trained therapist's time in this way in instructing the patient in what he can do for himself is productive of more results than administering various forms of heat, massage or electrotherapy. The current shortage of physical and occupational therapists undoubtedly has delayed to some extent the more widespread use of physical methods in medical practice, but one sees this shortage being gradually corrected. Most therapists at present are grouped in rehabilitation centres or the physical medicine departments of general hospitals. With developing arrangements for needed rehabilitative medical services at out patient and community level and the increased knowledge and interest of the practising doctor in this branch of treatment, more therapists in future will be treating the problems of general practice than at present.

Acute Illness Group

The great majority of any doctors's patients at any one time have acute or short-term conditions from which the majority rehabilitate themselves. Others with orthopaedic, corrective surgical and non-surgical injuries often require physical medicine assistance. In contrast to normally well people

with acute illness, persons with a previous disability will usually only reach their former level of function after acute illness with help from the rehabilitative medical staff (physical medicine specialist, physiotherapists, occupational therapists) and some time in an organized physical medicine department. It is to be stressed that to be effective physical medicine must be started as early in the case as possible.

Continuing Care Group

A smaller proportion of the caseload of the doctor will require continuing medical services (long-term or permanent) and these almost regularly need attention from the physical medicine staff. We have already referred to the stroke group where now we can expect two-thirds to be able to function again in their own homes, and a further portion capable of sufficient self care to enable them to carry on at supervised boarding home level. When we contrast this with the situation even a decade ago when at least two-thirds of stroke patients required permanent custodial nursing type of care, one becomes aware that doctors are recognizing the value of early treatment and activity programs generally, i.e., there is an awakening and acceptance of physical methods in medical treatment. This also infers the development of the team approach where, as well as the doctor, nurses and therapists, the social worker and home visiting nurse and home visiting therapist may be essential to the actual discharge plans of many patients.

Special Rehabilitation Group

Only a few cases in each doctor's practice will require a more extensive and more specialized rehabilitation prescription. These will be the ones with severe damage to the brain or spinal cord or multiple disabilities, e.g. multiple fractures or loss of limbs. Also included will be certain degenerative diseases of the nervous system or skeleton, extensive burns, etc. Such cases require the services of the physical medicine specialist and often the special rehabilitation centre and a more comprehensive attack on his problem than is usually possible to give at private practice level, though this depends a good deal on the interest of the physician and the resources available to him locally. These are the cases that lose their earning power for long periods and sooner or later become dependent upon community and

government funds for their care. Relatively long periods in the special rehabilitation centre may be required and these beds are too few and hence often unavailable. Expensive bracing or supportive equipment may be needed and the availability of these resources at local level may be quite unsatisfactory. Hence, unnecessary long-periods may occur when this type of patient receives inadequate treatment when in fact time may be most important to recovery of function. To avoid these gaps in management, an integrated program with adequate services should be available from the time of the patient's first admission to hospital. His rehabilitation plans should be considered as early as is practical, and he should proceed from stage to stage of his treatment in a positive way knowing what to expect and what will be expected of him. He will, if possible, have seen and talked to the persons concerned with his next stage of treatment whether it be another hospital, rehabilitation centre, or re-training area. If his disabilities are obviously such as to prevent him from returning to his previous employment, he will be vocationally tested as he proceeds with his medical rehabilitation and a training program selected. The occupational therapists of the hospital concerned can often do a good part of this. If he is to return directly back into some phase of industry, the placement officer should preferably meet him, get to know him, discuss job possibilities with him before he leaves hospital. It goes without saying that the placement officer should preferably have some medical and social background as well as his knowledge of the local industrial situation. In some cases, the paper-work analysis and medical examination do not sufficiently indicate a man's capability and nothing can take the place of an actual work test at the machines in a vocational workshop area.

Summary

1. Physical methods have their place in the treatment of most categories of patients and at all levels of care.
2. An expansion of physical medicine facilities is needed for in-hospital patients, but particularly for the up-patient group outside hospitals.
3. Satisfactory vocational rehabilitation must integrate closely with medical rehabilitation work and more liaison is required than exists at present.

(Continued on Page 31)

MEDICAL REHABILITATION IN WINDSOR

By JOSEPH BERKELEY, M.D., Windsor, Ont.

Medical rehabilitation has been defined by Dunlop as "Any medical, surgical or psychiatric treatment necessary to eliminate or substantially minimize any static or apparently chronic disabling condition, including the provision of necessary prosthetic appliances, and training in their use" (1). The author would add another service—the team evaluation of the disabled person, as this pertains to his living and/or working situation. It is, therefore, suggested that there are a minimum of five components necessary for a medical rehabilitation program: 1. Medical and surgical diagnosis, and definitive treatment; 2. Physical medicine evaluation and treatment; 3. Team evaluation by medical and para-medical experts of the severely disabled child and adult, with reports to and liaison with other agencies; 4. A central rehabilitation agency to co-ordinate all rehabilitation programming, and 5. Provision of financial assistance for patients requiring prosthetic therapy and evaluation program.

It is proposed to review the development of a medical rehabilitation program in the Windsor, Ontario area during a ten year period.

Situation in 1952

In 1952, Windsor, Ontario was a medium-sized, industrial community with an area population of 169,000 people. The area was served by three general hospitals, with a total of about 900 beds, plus a chronic disease hospital of 350 beds. Outside of the hospital setting, the widespread enrollment of most of the population in a comprehensive medical insurance program, (Windsor Medical Services) made medical care readily available on a broad scale. However, while definitive medical and surgical care was good, the secondary complications of many primary disorders were not well treated, eg. stroke, fracture, arthritis and neuro-muscular disorders. The lack of physical medicine programs in the hospitals and absence of physiatric treatment elsewhere meant that soft tissue problems, i.e. joint contractures, weakness or general deconditioning of bed rest, were neglected. The only physical medicine program was in an out-patient setting, and only a small caseload could be treated.

Many patients, with chronic crippling disorders who were transferred to the chronic disease hospital received comfortable nursing care, but there was no program to minimize local and general crippling, nor were there activity or motivational programs to encourage the patient towards maximal function or assist in the adaptation to residual disability.

Many patients, in the same category, who were discharged home from general hospitals struggled as best they could with problems, some of which could have been prevented or lessened by suitable physical medicine programs.

Patients requiring braces or prosthesis had to travel to another city for these appliances. Afterwards, many of them did not obtain adequate use from these appliances because of lack of after-training in proper usage. In other cases optimum benefits were not derived from these appliances because of deconditioning, or added deformities. If the adult patient could not afford the prosthesis, in most cases, he or she did without. A local service club provided braces for the needy child.

Except in public schools, there was no speech therapy program.

Medical social service was non-existent. There was no team evaluation for the disabled patients, and no co-ordination or liaison with the vocational rehabilitation program.

Above all, there was a lack of knowledge in techniques and objectives of a physical restoration program among medical and nursing personnel, hospital administrators and those in charge of social and voluntary agencies. In fact there were many gaps in personnel, facilities and financial aid to disabled persons.

Changes by 1962

By 1962 the population of industrial Windsor and suburban areas had grown to 195,000. All hospitals were equipped with physical medicine facilities. At all hospitals in-patients annually received physiotherapy programming in the general hospitals. On a daily basis the caseload of all in-patients and out-patients receiving physiotherapy had jumped to 250. The turn-over of

patients annually, amounted to 3,500, compared to 300 in 1952. Registered therapists increased from three in 1952 to 16 in 1962.

A prosthetist settled in the area in 1955 and financial assistance has been available both for the provision of prosthetic devices and for after-training in their use.

Financial help was rendered through a rehabilitation agency which is also the focal point for planning and other services.

A speech therapy program had a caseload turnover of 150 annually, (excluding the school program). Three institutions had medical social departments.

Team evaluations were available for the multi-problem child, teenager, and adult, with liaison with vocational services. Educational programs were in effect in all the institutions. Plans for a central library on physical medicine and rehabilitation were initiated.

The Ontario Hospital school located in the area was the first hospital school in the province to have a physical medicine clinic and program for its in-patient handicapped patients. Fifty children received a physical restoration and maintenance program in 1962.

This figure did not include approximately 1,000 patients treated annually at the writer's private consultation office and physiotherapy treatment centre (where ambulant cases, e.g. neck, back, shoulder, hand disabilities receive physical restoration program)—nor the 250 cases who received electro-diagnostic studies as part of their evaluation (electromyography and recently nerve velocity measurements).

The table below shows particularly the increase in volume of physiotherapy during the ten-year period, as an index of the growth of the medical rehabilitation facilities:—

PHYSIOTHERAPY CASELOAD		
PHYSIOTHERAPY	1952	1962
	No. of patients discharged annually	
General Hospitals	no program	2,000 (approx.)
Chronic Disease Hospital	no program	300 (approx.)
Ontario Hospital School (opened in 1961)		50 (first year of program)
Out-patient Centre—		
Red Cross	250	1,000 (approx.)

Private Office of physiatrist	no program	1,000 (approx.)
Total	250	4,350
Daily caseload	20 (approx.)	250 (approx.)
Registered therapists	2	16

To study the way in which these programs began, we have to go back to 1954 when a group of interested persons approached the Windsor Community Welfare Council to discuss the problem of rehabilitation in this area. Committees were established to review the existing programs and needs in the three areas of medical, social and vocational rehabilitation. The Essex County Medical Society appointed a strong committee to review medical rehabilitation. This committee adopted a well-tried medical technique:—they called in consultants. These were Dr. K. Charron and Mr. Ian Campbell of the Federal Government, and Mr. James Band and Mr. Jack Amos of the Provincial Government. When the reports of all the committees were finally tabulated, three broad needs in the field of medical rehabilitation were exposed:—1. The creation of physical medicine facilities; 2. Education of doctors, nurses and agencies in their use; 3 The creation of a new agency, to act as a co-ordinating agency for all groups and also provide service to individual patients.

It may be of interest now to review the ways in which the Windsor community attempted to meet the problems exposed by its rehabilitation committee:—

Creation of Physical Medicine Facilities

General hospitals—While the central committee encouraged the creation or strengthening of physical medicine programs, each institution had autonomy to develop and organize its own. In one hospital the new department of physical medicine was organized as a sub-section of surgery, later gaining department status on its own, and having representation at medical board level. This procedure was followed in another general hospital, and has the advantage of encouraging direct contact with the chiefs of other departments during

(Continued on Page 25)

"COMMUNICATION AND VOCATIONAL REHABILITATION OF THE DISABLED"

By C. M. GODFREY, M.D.,

Clinical Teacher, Division of Rehabilitation Medicine, University of Toronto,
and

Director, Course in Speech Pathology and Audiology, University of Toronto.

We live in a verbal society. Premium is placed on the ability to communicate clearly, concisely and quickly. A child's place at the table, a teenager's niche in the crowd, a woman's part in a service club, or a man's desk in the business world—all depend on the ability to make wants known and ideas accepted. And while society will stand and wait for a disabled person to crutch his way laboriously on to a bus, that same society won't wait to hear you cry "help" if you stutter, speak indistinctly, or have some word-finding difficulty.

Yet many people in our society have speech defects—about 5 per cent. Of this number, more than half of the difficulties are developmental, getting worse as the child becomes older and, in many cases, limiting the educational aspirations, social contacts, and emotional maturation. Performance in school can be affected seriously by a lateral lisp. The child avoids reading aloud and tries to cover up the deficit which causes other children to snigger and teachers to punish. Many reading difficulties can be traced to inadequate speech performance.

A teenager with an articulation problem which makes verbal speech indistinct will be forced to consider employment where he does not meet the public or speak on telephones. This narrows the field of his choice. A twenty-year-old who is a secondary stutterer, struggling to say a word without body gesticulation or spasms of silence, is limited to an occupation where he has little oral contact with customer or fellow employee. And there are just not enough openings for wireless telegraphers left in the world.

Another factor influencing vocational aspirations may be the inappropriate voice. The student

may be able to survive the huddle even though he calls signals in a squeaking voice but a falsetto voice in a six-foot-tall male teacher is just not tolerated by the students. Our society prides itself on the virility of its manhood and a failure to speak with an adult pitch may cause a wide detour in the normal progression towards a worthwhile goal. Teachers, ministers and others who address large bodies of people are required to have a speech apparatus which will stand up to the strains of over-usage—and in some cases mal-usage. Failure to speak without tiring and huskiness has limited the remarks of many an after-dinner or platform speaker. While this may be a relief to the audience, it means that the public relations program which is being carried on by a service club may have its appeal cut in half with subsequent drop in revenue and the attendant search for a new speaker on the next occasion.

Other Limitations

Other limitations, however, are forced on the adult aphasic. He is commonly a businessman at the peak of his career who has a sudden onset of hemiplegia on the basis of a cerebrovascular attack. This may be accompanied by aphasia. He may be rehabilitated to the level of self-care, walking and, in many cases, return to his desk. However, if he can't communicate, his placement in the business world in his former or a different job is an almost impossible situation. His communication difficulties may be that he cannot understand what is said or written, or it may be that he can understand but cannot say the word or idea he has in his mind, or it is more likely to be a combination of the two. In addition, he

(Continued on Page 27)

REHABILITATION: CONCEPT AND PRACTICE

By J. A. L. VAUGHAN JONES

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The word "Rehabilitation" has been used in many contexts and in many different ways. In the medical field its interpretation has changed considerably in the period from the years before the First World War to that after the Second and the ensuing extensive social legislation which followed the Beveridge Report. Changes in definition, although usually enlarging the scope, do not necessarily mean increased application. The multiplicity of statutory and other agencies which have a part in the method and means of returning patients to full industrial and social contact has contributed to the failure to progress with the changes in definition.

Any review of rehabilitation services in this country shows many gaps which are due primarily to a failure by the medical profession as a whole to accept the dynamic philosophy of treatment demanded by rational schemes of rehabilitation and secondarily to the failure of effective co-ordination and integration between governments, hospitals, general practitioners, public health services, and industry.

Prevailing Tendency

The prevailing tendency to isolate rehabilitation in the sphere of physical medicine is criticized as an attempt to evade a responsibility which the whole practising profession must accept. The fundamental function of industry in the process and the importance of the role of the industrial medical officer are emphasized. Resettlement in employment is the crux of the whole process of rehabilitation.

* * *

In choosing the title, I wondered whether to concentrate on a purely academic approach or whether to detail my experience in a particular branch of medicine relating mainly to industry. In the end I have compromised by a combination of both. First an interest in occupational health, which began as a student, was stimulated when I was thrust into the vortex of the daily casualties of a Welsh mining community. Rehabilitation



tion was a word used in limited circles, mostly outside medicine, and understood by few, but a youthful anxiety to try to get men back to work earlier than they did in those days of 1924 was the glimmering in my own mind of our modern approach. This was no pioneer work; it had already been undertaken by Robert Jones, Agnes Hunt, Moore at Crewe, and others, but it was an instinctive reaction to the months of suffering and waiting which was the lot of many patients; waiting until the wounds healed; waiting until the claim for compensation, so bitterly fought, was settled; waiting to be allowed to recover their sense of independence; waiting to be allowed to face death daily at their work. It was not the hacking coughs and the marked dyspnoea of so many which were disturbing, as

much as the poor results of the traumatic surgery of the era which constituted a major challenge.

Immobilization for months in splints and later in plaster, more months spent hobbling about aimlessly trying to restore function in limbs too long rested and wasted, months spent wrangling in the courts about differing and sometimes conflicting opinions of medical experts: months which embittered men and their families, and much of the blame could properly be stated to be the responsibility of a profession much too slow, or, to be charitable, too conservative to learn the lessons so clearly demonstrated to it by those pioneers in Britain before, during, and after the first world war.

Training All Types

It has been said that rehabilitation is physical medicine: how shockingly insular. I am not a physical medicine expert. Nevertheless, I have occupied a somewhat privileged position to survey the scene and watch the developments. In 1940, I became industrial medical officer at a Government Training Centre of the Ministry of Labour and National Service, training all types of people for work in the war effort, girls, women, boys, men, able-bodied and handicapped; all who could walk and breathe were potential trainees. The adaptation of down-and-outs, social outcasts, and quite severely-disabled persons to economic working units was a tremendous achievement, spurred on by the urgency of the manpower need of the war, but it provided a real insight into the problem, an insight into the potential of disabled or handicapped people who had been regarded as cripples with no future. This work continued during the war years, and when peace came, was adapted to the training of ex-servicemen for peacetime needs, for men and women who had lost their opportunities through their period of war service.

The Present Position

It is the lack of integration of all these services which has been the main delaying factor in the proper development of the scheme. If the problems of the different services are envisaged and particularly those of our own profession, it is realized first of all that there is an absence of modern thought in the teaching stage when the medical student is at his most impressionable age. The

problems of the National Health Service have almost engulfed the medical profession, which consequently has failed to appreciate the vital contribution which a dynamic philosophy of treatment can achieve. It has shown a lack of vision or even a desire to eschew anything which appears new (apart from drugs) and an almost fanatical belief in the methods of the past. It may be that the increasing fragmentation of medicine, particularly of the specialities, may have played a part in this. The welter of post-war social legislation has almost submerged all except the cynical, the embittered, and the angry, but positive constructive thought or action rarely emerges from these groups.

In spite of the brilliant achievements of a few enlightened doctors who had the courage of their convictions, too little has been achieved in the sphere of rehabilitation. Platitudes, professional jealousies, empire building on the part of lesser known specialties, apathy, and plain ignorance are charges which have to be met. One expert has divided the medical profession into five groups on their attitudes to rehabilitation: tolerant 30 per cent, passive 50 per cent, interested 15 per cent, enthusiastic 3 per cent, expert 2 per cent.

The past 12 years have been spent trying to educate, to encourage, to cajole, even to force, colleagues to appreciate that medicine now includes social responsibilities towards patients. These responsibilities must be accepted as a fundamental part of the modern concept of treatment in that the work is not completed until the patient is back at work, properly settled in appropriate employment. This new concept of treatment also demands that doctors are part of a team which involves many other agencies. Doctors are essentially individualists, but occupational health shows that success can be achieved only as members of a team; this is equally true in the concept of rehabilitation.

Accept Philosophy

There is one bright light on the horizon, and that is the avidity with which final year medical students accept the philosophy of rehabilitation and ask for more in the few lectures which are allowed in the curriculum. The tragedy is that rehabilitation should not be taught as a specialist subject, but as an inherent part of all clinical teaching; that will be too much to expect of

this decade. Nevertheless, junior resident medical staff are more ready to accept this wider concept than their seniors, and one regional hospital board, at least, has instituted courses in rehabilitation for junior resident hospital medical officers during their first two years. This sensible action should be copied nationally.

Many general practitioners are more knowledgeable about this problem than is generally realized.

Industrial medical officers play an important part in the resettlement of the individual returning to industry; the industrial medical officer often has the extremely difficult task of relating an employee's altered capacity to the jobs which are available. The detailed results of the follow-up (of these cases once they are back) in industry can assist the other services engaged in rehabilitation to a very considerable extent; in addition the information available from the industrial medical officer has not been fully used.

To turn now to the statutory authorities. The Ministry of Labour, under the impetus of the Disabled Persons (Employment) Act, has probably made a greater contribution to the subject of rehabilitation than any other Department by the provision of disablement resettlement officers at every local Employment Office, a corps whose training has been steadily increased and improved since 1944; by its Industrial Rehabilitation Units which carry out the work of reconditioning people returning to their own or other work or assessing cases requiring a change of work or training; by its Medical Interviewing Committees which give medical advice to assist the D.R.O. in the placing of disabled persons; by its Government Training Centres, which train both disabled and able-bodied for new vocations, and its Remploy Factories for the more seriously disabled; and by its Disablement Advisory Committees, dealing with local problems.

Helping Handicapped

In recent years the Ministry of Health, particularly since the publication of the Piercy Committee Report, has advised regional hospital boards, boards of governors, and local authorities to tackle the problem of rehabilitation, the problem of handicapped persons of all ages. The Ministry has issued documents to the hospital service,

the local authorities, and to general practitioners on the general problems of rehabilitation, and has encouraged boards and hospitals particularly concerned, not only to develop, but to make the best use of existing facilities and to provide facilities for a system of planned convalescence. The streamlining of these rehabilitation services, run under the aegis of the Ministry of Health, could save the National Health Service millions of pounds and would reduce the demand for more hospital beds which is often made. The increased use of this new concept of treatment means a shorter hospital stay and a quicker return to work. These are basic factors in the national economy.

The Ministry of Health in a circular to regional hospital boards and boards of governors stated:

"Rehabilitation is not to be regarded as the application of special techniques, and still less as a separate medical or other speciality, but above all, as a constituent part of the thought and action of all those who are concerned with treating patients and the restoration of disabled persons to their utmost capacity."

In spite of this, the Ministry of Health in its circulars has tended to concentrate on a thesis of physical medicine as expressed by physiotherapy, remedial gymnastic, and occupational therapy services, rather than to demand from the medical profession the individual and collective response which is its right. It is important not to build a rehabilitation service entirely on a basis of physical medicine. Of the groups which comprise the profession, the orthopaedic, traumatic, and thoracic surgeons, the chest physicians, the psychiatrists, and the physical medicine group have shown a greater willingness to accept the additional responsibilities of treatment than others, but it is emphasized that rehabilitation is one of every doctor's fundamental responsibilities.

Both departments have encouraged the use of resettlement clinics or case conferences at every major hospital, i.e. clinics in which consultant, almoner, disablement resettlement officer, and doctor with knowledge of local industry can pool their knowledge to the benefit of the patient, but the response has been completely inadequate.

(Continued on Page 28)

THE NEED FOR MEDICAL REHABILITATION: EXPERIENCE IN ALBERTA—1956 - 1959

By M. T. F. CARPENDALE, M.D., M.S.

Rehabilitation is like an iceberg. The problem that is seen, and whose size, shape and consistency can be analysed, is only a small portion of the whole. The larger portion of the problem is hidden and though its size may be guessed at, its shape and consistency are more difficult to determine. That the unseen problem is nearly always much larger than anticipated, has certainly been our experience in Alberta. It was felt that this experience might be of value to other areas in establishing rehabilitation programs under similar circumstances because, in some way, events in the past few years in Alberta presented unique opportunities for gathering information with regard to, not only the size, but also the shape and consistency of the problem.

Population Comparisons

The province of Alberta occupies approximately a quarter-million square miles, and has a population of just over one million persons—i.e. —an average of about five persons per square mile.

In size, the province is comparable, in the continent of Africa, to Kenya—but one-fifth of its population; in Asia, to Burma—but only one-twentieth of its population; in Australia, to South Australia—both in size and population; in South America, to Chile—but only one-fifth of its population; in North America, to Texas—but one-eighth of its population; in Europe, to France—but one-fortieth of its population.

From this data, one may appreciate that, compared to many countries, Alberta is a sparsely populated area. Approximately half the population is situated in the two largest cities, Edmonton and Calgary. Edmonton, which is the capital, and centrally located in the province, is a town of just over a quarter million (260,733—1959). The University Hospital, which is the largest hospital

in Alberta (now 1200 beds), is located in Edmonton. This hospital has had a physiotherapy department since 1930, and a psychiatrist since 1945.

In 1952 most people would have considered that facilities for medical rehabilitation were adequate for the population and compared favorably with other areas in North America, even those more densely populated. In 1953 a poliomyelitis epidemic demonstrated that facilities were quite inadequate on such an occasion. In this epidemic, 1399 cases were reported, of which, 356 had respiratory involvement and of the total, 151 died. On one occasion there were 80 patients with respiratory involvement in the hospital at the same time.

New Facilities

Public interest was aroused and a demand made for more adequate facilities. The government (which was responsible for the financial care of poliomyelitis) provided for the construction of a new wing for the University Hospital, which it felt would be adequate to take care of any future epidemic. This new wing was to have 200 beds, of which 70 were designated for respiratory poliomyelitis, and on the main floor there was to be a department to cover every phase of medical rehabilitation. This department occupies about 20,000 square feet.

Critics of this plan stated that at that time no known hospital rehabilitation department in North America had ever been so large, and considering the sparsely populated nature of the province it was unnecessary, grossly extravagant and quite unjustified. These same critics became more vociferous in 1954, with the advent of Salk Vaccine, and stated that now there would be even less reason for construction of the new wing. In spite of these severe criticisms the building was finally completed and occupied in 1957.

Because of the criticism and the subsequent course of events, it was felt it would be of interest to make comparison between the work load in

the rehabilitation department in 1956 (one year prior to moving into the new wing) and in 1959 (two years after the move was accomplished).

Analysis of this data, shows that between 1956 and 1959 in the overall population in the province of Alberta there had been a 12.9 per cent increase—from 1,123,000 to 1,268,000, while in the city of Edmonton there had been a 16.6 per cent increase—from 223,540 to 260,733. At the same time there had been a 28.3 per cent increase in the total beds in the University Hospital, from 897 to 1151. By contrast, in the rehabilitation department, while there was only an increase of 25 per cent in the number of staff, from 26 to 32, there was a 56.8 per cent increase in the number of patients treated in rehabilitation, from 2013 to 3338, and a 76.8 per cent increase in the number of patient-treatments, from 64,013 to 113,269.

Further Analyses

These figures indicate the size of the problem, but not the shape or consistency. For instance, the amount of work involved in any patient-load depends not only on the number of patients, but also on the conditions treated. (e.g.—one paraplegic may daily require three or four times the amount of work necessary for a patient who has suffered a sprained ankle; not only will he require more daily treatment, but it will continue over a much longer period). For this reason, two other analyses have been made.

The first was a spot check on one day of all the different patients, by diagnosis, attending the department. This showed that on July 29, 1958, 118 patients were treated in the Rehabilitation department of the University Hospital. There were 93 patients with disorders of the locomotor system, including: disorders of the spine, 18; arthritis, 52; fractures, 17; amputees, six. There were 100 disorders of the nervous system, including: cerebrovascular accidents (hemiplegia), 4; poliomyelitis, 39; spinal cord injuries, 17; brain injuries, 5; miscellaneous neurological disorders, 15. There were 24 psychiatric disorders and 101 miscellaneous disorders.

These figures suggest a heavy patient-load, not only in the numbers, but in disabilities on that particular day. To see if this occurs most of the time, so that this would not reflect one particular day or month, a second analysis was made of

new patients who registered in the Rehabilitation Department, for the six months between July 1 and December 31, 1959, by diagnosis. This showed that 3,500 new patients were registered during the last six months of 1959. Of these, 764 were disorders of the locomotor system, (including, disorders of the spine, 50; arthritis, 194; fractures, 114; amputees 12); 230 were disorders of the nervous system, including (polio, 71; C.V.A., 55; spinal cord injuries, 11; brain injuries, 10; miscellaneous, 13); 227 were psychiatric disorders; 141 were surgical conditions; 73 were medical conditions; 34 were gynaecological conditions; and 1,977 were registered for chest physiotherapy or perinatal classes.

Major Points

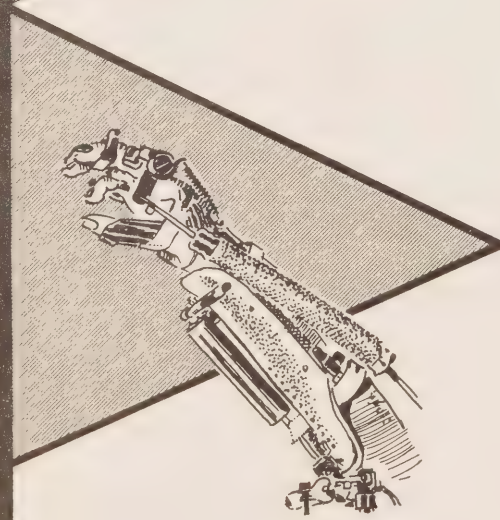
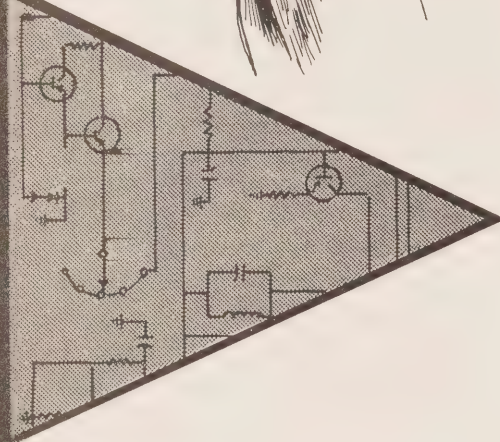
Two major points of interest emerge from these figures. Firstly, that after increased facilities for medical rehabilitation were provided, the number of patients treated increased 56.8 per cent and patient treatments increased 76.8 per cent. This increase was much greater than, and could not be accounted for by, the increase in population of the city or province, or bed capacity of the hospital, which had increased only 12.9 per cent, 16.6 per cent and 28.3 per cent respectively. The evidence strongly suggests that these patients who formed the increased patient-load were present prior to the construction of increased facilities but were never reached or provided with adequate treatment. They constituted part of the hidden and unmet need in medical rehabilitation in Alberta.

The second point is, how this problem compares in size to other centres. Confidential reports received from nine other leading university centres in the United States of America indicated that only one other centre handled such a large patient-load.

These two points suggest one conclusion and one question. The conclusion is—that no matter how big your rehabilitation facilities may be, they seldom seem adequate to meet all of the hidden need, i.e., one nearly always underestimates the size of the iceberg. And the question is this—if a province as sparsely populated as Alberta needs facilities as large as any in North America to meet the hidden need for medical rehabilitation—surely a greater need must exist in the more densely populated corners of the country?

ELECTRONIC CONTROL OF PARALYSED LIMBS

By R. N. SCOTT, University of New Brunswick



If current research is successful it will some day be possible to control paralysed limbs without orthotic appliances. More important, it is already possible for even the most severe quadriplegic to control powered orthotic appliances capable of very complex motions. However, systems which provide this capability are not generally available. We have been unwilling to divert the necessary effort from the important problems of our increased luxury and improved defence to bring such systems to more than laboratory prototype status.

A concerted effort to apply the latest scientific and technological knowledge to the development of powered orthotic systems began recently in the United States. Coordinated by the Committee on Prosthetics Research and Development of the National Academy of Science—National Research Council, major research projects are now under way at the Engineering Design Centre, Case Institute of Technology, the University of Michigan and several other institutions. It would normally be a considerable time before the results of this work become available to Canadian patients. However, it is hoped that the efforts of a new voluntary agency in New Brunswick will expedite the northward transmission of information in addition to supplementing the U.S. research.

Research in New Brunswick

The present research in powered orthotic systems in New Brunswick began with a request by Dr. Lynn Bashow to the University of New Brunswick for assistance in the rehabilitation of a quadriplegic at the Forest Hill Rehabilitation Centre. The enthusiastic reception accorded the attempts to meet this request led some members of the University faculty to consider seriously the application of their skills and knowledge to the rehabilitation of the physically handicapped. Con-

sequently, the Technical Assistance and Research Group for Physical Rehabilitation was formed in June, 1962. The purpose of this Group is:

"to assist the medical profession in the diagnosis, treatment and rehabilitation of the disabled, with particular reference to the rehabilitation of the physically handicapped"

This article outlines some possibilities of externally-powered orthotic systems, and explains the role which the Technical Assistance and Research Group for Physical Rehabilitation (TARGPR) hopes to play in making such systems available in Canada.

Perhaps the most important application of externally-powered orthotic systems is the restoration of upper-limb function to quadriplegics, especially quadriplegics with total paralysis of all four limbs. These persons present the greatest difficulty in providing controls for the orthotic appliance, but their confinement to bed or wheelchair minimizes restrictions on the size and weight of the orthotic system. Advances in upper-limb systems will be applicable to lower-limb systems but the greater power required and the need for complete portability are additional problems which will delay development of lower-limb systems.

Also, control systems which are satisfactory for orthotic devices will usually be satisfactory for prostheses. Thus any major improvement in the control of powered upper-limb orthotic devices has wide application. The following discussion relates specifically to upper-limb systems for total quadriplegics, i.e., persons with total paralysis of all four limbs.

Two Units

An externally-powered orthotic system may be divided into two fairly distinct units, the powered appliance (including energy storage facility) and the control system (including provision for two-way "communication" between the patient and the system). Some design considerations apply to both units. They must be compatible, and together must meet the requirements of performance, size, and weight imposed upon the system. The system must be safe. Routine harnessing and adjustment should not require the services of

highly-trained personnel. These considerations are obvious (at least after they have been stated). The most important consideration, equally obvious but most easily forgotten by the designer, is that the system must be acceptable to the patient. It is easy to neglect the psychological effect of the system upon the patient, using the urgent need for the system as an excuse. But there is no excuse for creating a scientific and engineering masterpiece (which any good powered orthotic system will be) if this system is offensive to the intended user. The object is rehabilitation, not advertising.

The Appliance

As suggested at the beginning of this article, it may eventually be possible to eliminate the orthotic appliance as we now know it and to provide direct electronic control of paralysed limbs. This would involve electrical stimulation of denervated muscle in response to a control signal initiated by the patient. Some research is being conducted in the United States regarding the effects of long-term electrical stimulation of muscles, with particular attention to the permissible electrode current density. (This will be important with chronically implanted electrodes). Enough progress has been made in simultaneous stimulation of several muscle groups to indicate the feasibility of thus producing coordinated motion. However, several years' work will be required to develop a practical system. Also, this technique will not be applicable to persons whose paralysis resulted from, or has caused, severe deterioration of the muscle (in contrast to paralysis resulting from denervation of otherwise healthy muscle). For these reasons, the development of powered orthotic appliances must be continued.

The design of a powered orthotic appliance centres around the selection of an actuator. Electric motors, hydraulic and pneumatic piston-type linear actuators and the braided "artificial muscles" have been used. Current opinion seems to favour piston-type pneumatic actuators, preferably operating at from 50 to 100 p.s.i. pressure. There is a need for a lightweight electric or electromechanical linear actuator but it seems unlikely that such a device will soon supplant the simple piston actuator. Thus, although energy to

operate the appliance may be stored more conveniently in electric batteries, compressed gas storage is dictated by the available actuators. At present, carbon dioxide is the favoured gas for reasons of economy, availability, and safety.

With the actuators selected, an appliance may be designed to support the limb and execute complex motions. One available appliance provides five independent motions of the arm, in addition to a gripping function between the thumb and the first two fingers. Problems facing the appliance designer are, in general, those encountered by the designers of non-powered appliances. These include problems of fitting, secure yet non-irritating harnessing, and appearance, in addition to mechanical function. These problems are greatly aggravated as the complexity and power of the appliance are increased.

All will agree that present appliances are not ideal, nor even adequate. However, appliances exist. At the present time a control system which will enable the "total" quadriplegic to use these appliances does not exist (that is, in the sense that it could be provided to a patient outside a highly-specialized research laboratory). The capability of powered orthotic systems used by quadriplegics will, for some time, continue to be limited by the control system. Thus, development of a suitable control system is of paramount importance.

The Control System

At present, any control system will depend upon voluntary contraction of skeletal muscles. (A possible exception, the use of audible commands, is not considered here because it is highly susceptible to interference). Some controls use relatively gross movements. For instance, a patient may operate an alarm by pressing his head against a switch. Or, at a higher level of control, he may drive a powered wheelchair with a control stick held in his mouth. There is clearly a practical limit to the capability which may be achieved in this manner, especially if "feeder" appliances are desired, for then the patient must be free to move his head in order to eat.

The tendency has been to utilize movement of the muscle to actuate a mechanical control device (a transducer), such as a valve or switch. This

leads to at least two problems. Firstly, there is the problem of harnessing. Even for on-off control using very sensitive transducers it is difficult to achieve reliable harnessing which will not cause skin irritation. Also, certain muscles are situated in locations which make this sort of fitting impossible. Secondly, the physical effort required to operate the system may be excessive. This may be true even when a very sensitive actuator, such as a "microswitch", is used; it may be necessary to mount the transducer so that the energy of the muscle contraction is used very inefficiently.

A new approach has been to eliminate these problems by using the muscle action potential as the (electrical) control signal. This electrical potential, which accompanies any muscle activity, is very small (10 to 100 microvolts peak-to-peak), with a frequency spectrum extending from about 10 to 1000 cycles per second. But the source of this signal lies within the human body, the control equipment outside. Here, in getting the signal from inside to outside the body, lies a new problem.

One can use surface electrodes, as in electrocardiography. These, however, are not very selective; they "pick up" signals from adjacent muscles. Reducing the electrode area, in an attempt to increase selectivity, increases the electrical impedance of the electrodes which is already too high for good performance. Also, repeated application of small surface electrodes at the same location causes severe skin irritation. The ideal solution is a wireless transducer, surgically implanted beneath the skin near the controlling muscle. While awaiting development of such a device, a promising interim technique has been adopted by the TARGPR. This Group has had very encouraging results using small (.004" diameter) stainless steel wire electrodes inserted (with a hypodermic needle) through the skin into the muscle. Selectivity is good, impedance is low, and irritation and infection have not proved to be serious problems.

No Technical Difficulties

Electronic processing of the control signal does not present any technical difficulties, except perhaps in reducing the system cost to a "reasonable

value. Control systems, built or proposed, range from simple on-off control of a single function to complex stored-program systems where a single command initiates an intricate series of movements (such as brushing the teeth). In designing these systems, our enchantment with science fiction should be tempered with glimpses of reality. We desire rehabilitation, not automation, of the patient. It is essential that we place the psychological reaction of the patient to any proposed system before all other considerations.

A neglected, but important, control problem is that of providing feedback of information from the appliance to the patient. With no sensory function in his paralysed limb, the quadriplegic is entirely dependent upon sight to determine the position and activity of the limb. Such important quantities as temperature and pressure cannot even be estimated by visual means. As powered appliances become more complex, the need for a supplement to visual feedback will become more urgent. At present, there is little or no research directed specifically to the development of such feedback methods.

Role of the TARGPR

To explain the role which the Technical Assistance and Research Group for Physical Rehabilitation hopes to play in this work, a brief description of the Group is necessary. The TARGPR is a voluntary association of engineers, medical doctors, and others numbering 17 persons in all. It is affiliated with the University of New Brunswick and the Forest Hill Rehabilitation Centre Inc., and facilities of these institutions are available for the work of the Group. Aside from its general service and advisory function, the chief project of the Group is the development of improved externally-powered orthotic systems.

Financial support has been received from a number of sources. Grants have been received from the New Brunswick Co-ordinating Council for the Handicapped, and donations from students of the University of New Brunswick. A Research Grant has been awarded by the Department of National Health and Welfare. (This grant is administered by the New Brunswick Department of Health). The New Brunswick Research and

Productivity Council has undertaken a program of electronic equipment design and development, with the object of encouraging manufacture of the equipment needed for these control systems. Predictably, however, the chief problem of the Group is still money; money to engage full-time staff and graduate research assistants, and to purchase additional research equipment.

TARGPR research to date has been essentially a feasibility study of the use of muscle action potentials as control signals for orthotic systems. Having established the technical feasibility of such a system, experiments have been conducted to determine the ability of a person to learn to contract specific muscles voluntarily. Results have been very encouraging, and a report on this work is being prepared for publication.

During this summer, a CO₂-powered upper-limb system will be assembled for a patient at the Forest Hill Rehabilitation Centre. The orthotic appliance has six independent functions. The initial control system will use photoelectric selection of the desired function, with muscle action potentials used to control the activation of that function. Also during this summer, possible coding techniques to obtain a greater number of control signals from a limited number of muscles will be studied. Development of improved actuators will begin, with emphasis on electromechanical actuators.

The staff of the TARGPR, for the summer period, will consist of one mechanical engineer, two to four graduate students in electrical engineering, and one undergraduate student assistant, (in addition to the New Brunswick Research and Productivity Council staff engineer engaged on associated electronic equipment design). This seems woefully inadequate, especially if compared to the most modest research programs elsewhere. However, all work to date has been accomplished with no staff, in the "spare time" of the TARGPR members. Thus, a considerable acceleration of the work is anticipated.

Robert Nelson Scott was born in New Brunswick and received his B.Sc. in Electrical Engineering from the University of New Brunswick in 1955. He has also had training as a teacher and a researcher in electronics. He worked for one year with the Northern Electric Company in Montreal and has been associated with the National Research Council and the Defence Research Board. He is now Assistant Professor of Electrical Engineering at the University of New Brunswick and President of the Technical Assistance and Research Group for Physical Rehabilitation (TARGPR)

People and Events

National Advisory Council Meets in Ottawa

The National Advisory Council on Rehabilitation of the Disabled met in Ottawa, May 13 and 14, followed by a three-day meeting of provincial co-ordinators. Details of these meetings will be included in a future issue. In opening the Council meeting the Honourable Allan J. MacEachen, Federal Minister of Labour, assured Council of the very deep interest of himself and the Honourable Judy LaMarsh, Minister of Health and Welfare, in its work. Mr. MacEachen said that he had already learned of some of the results of the program and appreciated both the humanitarian and economic values of helping disabled citizens to improve their positions in the labour force. He would support to the full, efforts to make this program successful.

Schools of Physical Education and Rehabilitation Expanded

The University of Montreal has purchased the Davis YMHA building on Mount Royal Boulevard to expand its schools of Physical Education and Rehabilitation. The building was handed over to the University on June 1 and should be ready for occupation this Fall.

The shortage of qualified physical education teachers, physiotherapists and occupational therapists prompted the University to expand in these fields. Msgr. Irénée Lussier, Rector, declared the new facilities will provide for increased enrolment.

Rehabilitation Institute of Montreal Officially Opened

The Rehabilitation Institute of Montreal officially opened its new building at 6300 Darlington Avenue on Saturday, March 9, 1963. The Hon. George Marler, Attorney-General and Minister of Cultural Affairs, representing Premier Lesage, unveiled a bronze plaque commemorating the event. Mr. Marler described the new \$3,500,000 hospital as a "modern success story". This story began in 1950 when, with a staff of four persons which included Noel Meilleur now Assistant Co-

ordinator, Civilian Rehabilitation, Real Rouleau now Assistant Director, Unemployment Assistance, National Health and Welfare, and Mrs. Helen Lippay, secretary, the Institute, under the direction of Dr. Gustave Gingras, first opened its doors in small quarters in the old Place Vigor Hotel building. It soon had to move to somewhat larger quarters on Craig Street and in September 1952 moved to the Montreal Convalescent Hospital where it continued to operate until its new up-to-date hospital building was ready for occupancy in February 1962. Today the Institute has a staff of 167 and is equipped to provide a variety of rehabilitation services to both children and adults. During the 12 years since its inception more than 10,000 persons have been served and the Institute has gained recognition as a leader in its field not only in Canada but throughout the world.

Dr. Gustave Gingras, Executive Director, is a consultant to the United Nations Technical Assistance Administration.

The Institute has provided training in physical medicine to 22 doctors, 13 from Canada and the others from Venezuela, Israel, Turkey, Greece and Spain.

Marina Creations Opens Store

Marina Creations, which since 1955 has been providing opportunity to homebound handicapped individuals to make and sell articles of artistic quality and excellence of workmanship, has opened its own store at 281 Avenue Road in Toronto. It is felt that this will make it possible to expand this program and give opportunity for more homebound workers to participate.

New Clinic Provides Needed Service In the Maritimes

A New Hard of Hearing and Speech Assessment Clinic, the only one of its kind in the Maritimes, opened on January 7, 1963 at 1318 Robie Street in Halifax. The major goal of the clinic will be to try to diagnose hearing problems at as early an age as possible and enrol small children in the Halifax Preschool Class for deaf children.

The Clinic will provide diagnostic services, treatment and counselling for both children and

adults. Hearing aids will be supplied when required along with instruction and training in their use.

Dr. Arthur C. Shane is Medical Director and Otolologist, Dr. Helen M. Hunter, Paediatrician and Dr. Adam J. Sortini the Audiologist, Speech Pathologist and Administrator.

K. Vernon Banta Retires

Just one month short of 43 years in state and federal service in the United States, K. Vernon Banta, Deputy Executive Secretary of the President's Committee on Employment of the Handicapped retired on April 1. He pioneered much of the work of this committee and has contributed a great deal to work for the handicapped, in the process earning for himself the title "Father of Selective Placement".

He has received many honours for his work in rehabilitation, including the Faulkes award of the National Rehabilitation Association. He has also been given the Labor Department's Distinguished Service Award. Mr. Banta has visited Canada frequently and is well-known to all engaged in rehabilitation and special placement work.

C.H.S. Opens New Office

The Canadian Hearing Society has opened a branch office in Ottawa, known as the Eastern Ontario Regional Office of The Canadian Hearing Society. It is located in Central Chambers, 46 Elgin Street. Mr. E. Joseph Hemming, CPO, RCN (Ret'd), is district officer.

Honorary Degree to C.R. Ford

C. Ross Ford, Director, Technical and Vocational Training Branch, Department of Labour, Ottawa, was one of three persons who received Honorary Doctor of Laws Degrees at the Spring Convocation of the University of Alberta on May 1. The degree was awarded to Mr. Ford in recognition of his distinguished contribution to education in Alberta and across Canada.

New Films

"*Just Around the Corner*" was produced for the Canadian Arthritis and Rheumatism Society in Vancouver. In this excellent film, light is thrown on C.A.R.S.' never-ending fight against the dread disease, arthritis, laying stress on that all-important means of finding the cause of and cure for arthritis—Research.

Because C.A.R.S. feels it is to everyone's advantage to obtain information about arthritis and its associated rheumatic diseases, "*Just Around the Corner*" is available free of charge from C.A.R.S., 900 Yonge Street, Toronto, C.A.R.S., 645 West Broadway, Vancouver, or C.A.R.S.' Divisions in Calgary, Regina, Winnipeg, Montreal, St. John, and Halifax.

"*The Need to Work*" describes successful industrial therapy programs in two British hospitals, Cheadle Royal in Cheshire, and Glenside, near Bristol.

In the film Dr. Wadsworth, Superintendent of Cheadle Royal, and Dr. Early, consultant to Glenside, discuss ways of helping long-stay mental patients by giving them work to do under conditions which duplicate closely those in industry, with the aim of returning them to outside employment and normal community living. The film shows how the patients respond to this kind of work therapy. Glenside also helped to form a private company, largely independent of the hospital, with a board of directors representing various community interests, and provided work experience away from the hospital environment as preparation for a return to regular employment.

For information write to the Medical Film Center, Smith, Kline and French, 300 Laurentian Boulevard, Montreal 9, Quebec.

(Continued from Page 6)

understanding parents and teachers, supported by proper definitive medical treatment.

Experience at Lyndhurst Lodge

The results of this approach as outlined, viz.,—diagnosis, treatment, evaluation, restorative program—with emphasis on education, may be of some interest to you. The following cases are drawn from our experience at Lyndhurst Lodge in Toronto. Although we are established mainly for the care of spinal injuries, we have over the years admitted many other patients who we felt might benefit from this form of treatment.

The patients have been mainly adults, considering teenagers in this category. Only to a very limited extent have we treated children under twelve.

We have treated 1,363 individuals with paraplegia or quadriplegia—partial or complete. Of

this number, 257 are known to be dead, leaving 1,106 survivors. Of this group of 1,106, 489 are employed and 85 are attending school, which we hope will lead to employment. The total is thus 574 working or at school, which is 52 per cent of the total group.

By contrast in the younger group—that is, between 12 and 19, of whom there were 324 surviving, 30 per cent were gainfully employed and another 39 per cent were under vocational training leading to employment. It will be seen from this that the results of treating young persons are much better than with the older group. Fifteen percent of the total were of unknown status.

Dealing with this group of young people, 45 had broken necks, 21 of whom were employed or at school—that is, just under 50 per cent. Of those with broken backs who had preserved the use of their arms, 80 per cent were employed or at school.

Other types of individuals treated at Lyndhurst Lodge are those who have become hemiplegic, either because of strokes or head injury. There were 193 such persons, of whom 21 are now dead, leaving 172. Forty-four of those are at work or at school, which is 25 per cent of the total.

We also treated 40 with amputations. Some of these had two or even three limbs missing. In at least three cases, both upper extremities were missing. Of the group, four are dead, leaving 34, of whom 19, or 55 per cent are working or at school.

For many years we treated many people, seriously disabled by poliomyelitis, and to date have cared for 403 such persons. Fourteen are dead, leaving 389 living, of whom 302 are at school or at work—an achievement of 77 per cent.

From time to time we have cared for those seriously disabled by rheumatoid arthritis. Those afflicted were usually young, in their teens or twenties, but some had been so disabled since early life and were now in the middle years. There were 13 such cases, all of whom survived, and 11 of the 13, or 84 per cent are at work or at school. A number were rescued from homes for the

chronically ill. In none of them was there significant change in their disability, the success being achieved rather through helping them to live with their disability.

Conclusions

It will thus be seen that important factors are age and severity of disability. There is no doubt about it that advancing years constitute an added handicap and that a broken neck is more difficult to live with than a broken back. However, we also know that any man or woman who has achieved university graduation is almost invariably employed no matter how severely disabled and it matters not whether the education was obtained before or after the disability. High school graduation leads to employment in about 70 per cent of instances in the disabled, but public school, employment in about 40 per cent. I should point out that many who came to us with public school or the early years of high school behind them at the time of injury have progressed to higher levels of academic achievement, including university.

Our failures result, by and large, with patients who are unwilling to endeavour to cope with their problems, either because of hostility or lethargy and indifference or to discouragement, for many are faced with a long period of training if they are to achieve a high educational goal. Many, of course, are incapable of obtaining an education because they lack familiarity with the English language, are of advanced years, are not intellectually capable of learning but, I would reiterate, our failures are due mostly to our inability to motivate a patient so that he will strive to the utmost capacity. Despite what I have said about education, we have mentally retarded paraplegics who are employed simply because they are willing to work and are steady in their work habits. We have average paraplegics who cannot read or write who are employed for the same reason.

Rehabilitation of the disabled then at any age requires the inauguration of a plan of management for that individual not strikingly different from that of his non-disabled associates. In its simplest form it consists of doing what needs to be done to get the patient going again.

(Continued from Page 11)

the early phase of development of the program. In another hospital, however, the physical medicine department is a sub-section of medicine, and access to medical advisory board is through a standing committee of three, comprising orthopedist, surgeon and physiatrist, who is the chairman. Other patterns of development have also been recorded (3).

Chronic Disease Hospital—In the chronic disease hospital, after an initial phase of organization, the department is under the jurisdiction of the medical superintendent, and the physiatrist functions as a consultant to the hospital, and so at weekly team clinics (2).

Red Cross Centre—At the Cerebral Palsy and Crippled Childrens Centre a physiatrist is director, and also functions as chairman of an assessment team, responsible to a medical committee, which has representatives from all local hospitals and the medical society. The assessment team comprises orthopedist, psychiatrist, paediatrician, and physiatrist, with psychologist occasionally in attendance.

Education Program

The Physical Medicine Department in a general hospital exists to prevent avoidable crippling, but another important function is to educate doctors and nurses in aims and techniques of physical medicine. Nursing education is accomplished through regular lectures, clinical demonstrations and direct contact with nursing personnel by members of the department. Also nurses-in-training at the general hospitals visit the Crippled Childrens Centre and the physical medicine program and conferences at the chronic disease hospital. The most effective physician-education program results from discussion between the physician and physical medicine department personnel. When a physiatrist sees the need for a change of treatment or additional procedure, or for referral to another service, e.g., occupational therapy, speech or social service, or to a rehabilitation agency, the doctor in charge of the case is contacted, before any change is made.

Rehabilitation Conference—Monthly rehabilitation conferences are held in one hospital with attendance of in-hospital personnel and representatives from community agencies.

Physical Medicine Notice Board—In one hospital there is a notice board in the doctors' cloakroom, giving in summarized form, information in physical medicine procedures. The data is changed monthly, and topics have included neck traction, hemiplegia treatment, spinal joint exercises, the crippled hand and treatment of the long-term patient.

Creation of a Community Rehabilitation Agency

The discussions of 1954 had pin-pointed the need for a local rehabilitation agency. By October 1955, 30 local organizations which were concerned with medical, social and vocational aspects of rehabilitation, had been encouraged to band together and form the Institute of Physical Medicine and Rehabilitation of Essex County, Inc. The first step was the opening of a small office, through financial aid from the Community Welfare Fund of Windsor. The office was staffed initially by a part-time executive director who was a registered nurse with experience in public health and a strong interest in rehabilitation work. Later, with additional funds from the Rehabilitation Foundation, secretarial assistance and a full-time phone-answering service were provided.

Requests Varied

Requests for services for disabled persons are handled through this office. The requests are varied and include appeals for financial help for transportation to therapy or for braces or other rehabilitation appliances.

Whatever the problem, the Institute requires that the referral be forthcoming from the doctor in charge of the case, and for two main reasons:— 1. Access to the patient's complete medical history is necessary, and 2. It is important to encourage the general practitioner to continue his responsibility throughout the patient's physical restoration program, and thus familiarize the physician with the techniques of medical rehabilitation.

The Institute also found it necessary to have a medical advisor, whose function was two-fold: (1) To review with the executive director the histories of patients referred to the Agency, and screen the requests for services; (2) To recommend consultation, either medical or para-medical, e.g. psychologist, where this was indicated, and to arrange for consultation. Also, where team

assessment was required for complicated cases, he would act as chairman of either the medical or total assessment teams. A senior general practitioner accepted this position, being the recommended appointee of the Essex County Medical Society. Through this screening mechanism it was much easier to obtain financial assistance for needy cases from local service clubs, voluntary agencies, such as Rehabilitation Foundation, or local or provincial governments. Although the Institute had scanty funds of its own, its stamp of approval could channel funds from other agencies towards the person in need.

The assessment team for disabled children had been organized by the Red Cross Centre. Since 1962, however, the Institute, in collaboration with this agency and with education authorities, has been organizing team conferences for the teen-age child, for the discussion of vocational goals.

Federal-Provincial Funds—The screening function of the Institute has been applied to agencies and institutions as well as to individuals. Requests for physical medicine equipment for various institutions in the area were reviewed by a special board of the Institute whose stamp of approval indicated to the provincial or federal governments that the equipment requested was in accord with the needs of the area. In this way \$38,000 (approx.) of the medical rehabilitation grant was channelled into the area as new physical medicine equipment, thus providing a great stimulus towards the development of the program. (This figure includes \$1,800 for speech therapy equipment and for equipment for the Cleft Palate Assessment Team).

Wheelchair Apartments—When the City Council, in 1961, embarked on its redevelopment plan, the Institute submitted plans for six wheelchair apartments to be included in a new central housing unit. The apartments were especially designed for wheelchair patients, and are now in existence, the tenants being processed through the Institute's selection team.

University of Windsor—In 1962 the Institute met with representatives of the local university. Discussions were initiated on ways to facilitate the attendance at the university of paraplegic persons, and others confined to wheelchairs.

Speech Therapy—In 1955, the climate of enthusiasm for a medical rehabilitation program encouraged four service organizations to collaborate and sponsor the cost of training a speech therapist. From this modest beginning grew another voluntary agency, the Remedial Speech Assoc. of Essex County, Inc. which now employs three therapists, and at the present time is planning a special speech and hearing diagnostic centre, in collaboration with a study committee appointed by Essex County Medical Society in the fall of 1962.

Past Problems

In the past there was some lack of acceptance of prescribed exercise programs among nursing personnel. More serious than this was the lack of trained physiotherapy personnel. The first problem was overcome by perseverance. The second problem was met by modifying the program in some general hospitals, using orderly or nursing staff as "exercise aides", to carry out a program of simple exercises and activity for bed-fast patients. With the advent of trained personnel, the "exercise aides" either continued as physiotherapy aides in the department under the direction of the therapist, or returned to regular hospital work.

There are many unsolved problems in physical medicine, including the difficulty of organizing maintenance programs to prevent deterioration in patients suffering from chronic disease in institutions caring for both adults and children.

Also there is lack of good criteria to give an index of the quality of the physical medicine programs in the various hospitals.

Summary

The overall rehabilitation program in Windsor grew out of community planning.

The medical component of the program was guided by the local Medical Society. Their committee recommended: 1. The creation of Physical Medicine Departments in general hospitals; 2. The individual practitioner retaining responsibility for his patient during medical rehabilitation programs; 3. A medical advisor to the Community Rehabilitation Agency.

Over a ten-year period physical restoration programs have developed extensively and in a variety of settings in this industrial community.

cluding a private office where patients are treated within the general framework of the private practice of medicine. All facilities have been heavily utilized. While, in the coming years, techniques and details of organization will change, these programs appear to have an assured place in the medical services of the community.

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(Continued from Page 12)

may have lost his ability to write and to read or calculate. What rehabilitation officer or National Employment Service placement officer can find a job for this man?

Other speech defects in the older population may follow radical surgery or radiation—such as after carcinoma of the larynx. Such a patient is left without a normal air stream passing through the larynx into his mouth. There are very few jobs available for someone who can do nothing but write on a paper or whisper.

Fortunately, there is much that can be done with many of the conditions listed above. Physicians are more aware of the possibilities of treating and rehabilitating these people. Many of the patients require speech therapy and proper administration of the therapy shows gratifying improvements.

Teaching to Speak

A patient who has had extirpation of the larynx may be taught to speak using “esophageal” speech in which air can be stored in the esophagus and produced on demand to form words using the muscles of the throat and mouth. Many patients who have been limited have been retrained at the University of Toronto, Speech Therapy Clinic, at the Princess Margaret Hostel in Toronto. This Centre is operated in conjunction with the Ontario Cancer Treatment and Research Foundation. Of the more than 20 patients who have been seen and taught at this Centre, more than three-quarters have returned to their former job or have been relocated in another job.

Aphasic patients, if seen early enough, and treated aggressively enough, can show improvement in expression and reception of ideas, can be taught to write with the left hand, and put back into a work setting. Aside from the gratification the patient receives from his ability to socialize again, there is a distinct possibility with proper placement, he can once again fill a useful role in the business world.

The public speaker with hoarseness and easy tiring can be shown how to avoid vocal cord trauma and taught to avoid the set of conditions which seem to cause chronic cord inflammation. The teenage boy can be instructed in how to lower his voice pitch and sound like a “man”. Similarly, voices which are not pleasant and so limit vocational opportunities in selling or advertising fields, can be retrained to present the seller in a more acceptable light.

The stutterer can be taught to control his blocks, to reduce his symptoms and to get along more easily with his disability. He may have very little real change in the rhythm of his speech but his reaction to his speech may be modified and made more acceptable.

Modification of articulation faults can be made in school children by auditory training, speech therapy, and careful supervision of the learning situation. This requires adequate diagnosis of the problems by a trained speech therapist before specific therapy can be initiated. Children with cleft palates who may require operation will be seen post-operatively and treated to ensure an acceptable voice and enunciation. No more need they lose air through the nose to provide a target for school mates’ derision or imitation.

Speech which is not distinguishable because of substitution of the sounds, or strange intonation, can be repaired. This may, in some cases, require dental procedures or surgical procedures.

Teamwork Important

Of course, none of these procedures can be carried out in vacuum—we do not treat “the speech organ”. There is no speech organ. There is instead a complex individual who may have locomotion, respiratory, mental disabilities, along with some impairment of communication. To raise

the facility of communication, it is necessary commonly to have the whole patient go through a process of habilitation or rehabilitation. To do this may require the services of many members of the rehabilitation team—speech therapists, physiotherapists and occupational therapists, social workers, rehabilitation officers, psychologists, school teachers, dental officer and clinician.

The combined efforts of all of these people may be necessary to lift the glass cage which imprisons a person with a speech defect—a glass cage which permits him inside to see what is going on in the outside world and which prevents him from contributing to that world his ideas, skills and hopes.

(Continued from Page 15)

Terms of Reference

The Piercy Committee, a mainly inter-departmental committee, was set up by the Ministers of Labour and Health and the Secretary of State for Scotland in 1953 with the following terms of reference:

To review in all its aspects the existing provisions for the rehabilitation, training and resettlement of disabled persons, full regard being had for the utmost economy in the Government's contribution, and to make recommendations. The need for economy will be noted. This Committee arose from the Government's wish to ascertain what had happened as a result of the numerous legislative measures passed since the Tomlinson Report of 1943. The Committee finally reported in September 1956, after holding 54 meetings and taking voluminous evidence. In the interpretation of its terms of reference there was a significant change in the definition of rehabilitation. Paragraph 5 of the Piercy Committee's Report reads:

"The term 'Rehabilitation' in its widest sense signifies the whole of the process of restoring a disabled person to a condition in which he is able, as early as possible, to resume a normal life. With this interpretation, it would cover also training and resettlement in employment. As the terms of reference specifically mention re-

habilitation, training and resettlement, the Committee decided that its use of the term 'Rehabilitation' should be confined to medical and surgical treatment designed to restore physical and mental functions, and to the process of reconditioning, designed to restore the capacity for taking up employment or vocational training. Whilst the Committee was concerned primarily with vocational training for the disabled it decided to take account also of other forms of training of the disabled more strictly educational in content. It also decided that the term 'Resettlement' should be used to cover both the placing of disabled persons in employment (including any follow-up action to ascertain the effectiveness of the placing) and action taken to re-settle other disabled persons—such as housewives—who are not in the industrial field."

The separation of the terms "Rehabilitation", "Training", and "Resettlement" may indicate a desire to preserve Departmental tidiness, but this fragmentation tends to promote gaps when the whole process should be continuous.

The Piercy Report found omissions and deficiencies in almost every sphere and in every agency involved; deficiencies not only of personnel but also in the appreciation of the situation and its problems. Referring to administrative arrangements, the Report says (paragraph 317):

"To secure the most efficient operation of these services (from the standpoint of the individual) at the minimum cost in manpower and money, sensitive contact and willing co-operation are necessary between the various agencies and Departments concerned. This is needed at the centre, at the local level and among the regional authorities. The Committee believes that some improvement in existing conditions at all levels may be desirable, and is attainable."

This is a most masterly understatement.

The Committee finally made 46 recommendations, covering Hospital Services, Resettlement Clinics, Regional Hospital Boards, Rehabilitation Committees, Industrial Rehabilitation, Comprehensive Rehabilitation and Assessment Centres, Rehabilitation Services provided by employers, Welfare Services, appliances and other aids for

the disabled; Vocational Training, Disabled Persons' Register, Placing of the Disabled in Employment, Sheltered Employment including Remploy, Home Workers' Schemes and provisions for the young and other special categories of the disabled.

The Report was clearly a challenge to all participating authorities, but subsequent action was considerably delayed. It was not until 1958 that the Ministry of Health issued Circular H.M. 58) 57 on Rehabilitation in the Hospital Service and its Relation to other Services, and Circular 6/58 to Local Authorities on Services for Handicapped Persons. The Circular to general practitioners on Rehabilitation of the Sick and Injured appeared in July 1959, but was not circulated until further information as to available local facilities for rehabilitation was included as an appendix.

Action Taken

Several agencies, including Hospital Boards and Local Authorities, took positive action before the issue of these circulars. Indeed in 1949-50 the Regional Hospital Board had taken the action proposed by the second of the Piercy recommendations. The Regional Rehabilitation plan, evolved at that time by the co-operation of the Leeds Regional Hospital Board and the East and West Ridings Region of the Ministry of Labour, had reposed in the files of the appropriate Ministries since that time although the Chief Medical Officer of the Ministry of Health had expressed the view that this plan should be the pattern for all Regional Rehabilitation Services. It is interesting to relate that one Department denied that it had a copy of the plan.

Other Regional Hospital Boards are now engaged in an attempt to implement the recommendations of the Piercy Committee, and serious efforts are being made to improve the content of services, and to co-ordinate the various services. These efforts do not necessarily take the same pattern; for example, two adjoining regional hospital boards have entirely different concepts. One believes that all rehabilitation services should be based on the establishment of physical medicine consultants and centres at strategic points in the Region; the other board feels that one of its basic functions is to implant the ideology and philosophy of rehabilitation into all of its

consultants and hospitals. The results will be watched with considerable interest.

The Future

Making the assumptions:

(1) that hospital and general practitioner services can be improved to the extent that the responsibilities of rehabilitation are fully appreciated.

(2) that local authorities accept in full their responsibilities under the various enactments;

(3) that the various Ministries co-ordinate the work more efficiently and provide the necessary stimuli from time to time,

what remains to be done, and what should be done to anticipate the demand on other resources?

In the first place, is there the necessary link with industry to obtain resettlement? The link is probably there, but will not be efficient until there is a comprehensive Occupational Health Service in this country. Some large firms have achieved much in this sphere on behalf of their own workers, but at present their achievements cannot, for numerous reasons, be copied by the smaller undertakings.

There is a real need for the appreciation by all those engaged in the service of rehabilitation (both medical and lay) that entry into industry (and re-entry into industry) is no longer a slap-happy event, even although that term may still be applied to a number of school-leavers.

The relationship of the functional analysis of the worker to job analysis is an essential in the resettlement of the handicapped person. The techniques concerned should not be reserved for a small number of doctors who understand how to complete an official Ministry of Labour D.P. form and the disabled resettlement officers who frequently have to try to interpret the inadequacies of the medical profession in the completion of these forms.

It is not sufficient for the almoner at the behest of the disabled resettlement officers to chase the consultant to complete one of these forms, which may then be passed on to the senior registrar, the senior house officer, and finally the junior house

officer, who cannot pass it on to anyone else. The problem of equating a man's residual capacity to a particular job is often difficult, but until and unless the medical profession learns more of the pattern and reality of industry, schemes of rehabilitation will never attain the success they merit.

It may be argued that the simplest method for dealing with the problem would be to leave it to be settled by a few trained specialists. In my view this would be entirely wrong, because the philosophy of rehabilitation and the purpose behind it must reach and be accepted by all branches of the medical profession.

The work of the industrial medical officer in this sphere would assume reasonable proportions if a much clearer link existed between the agencies of the National Health Service and industry than at present. The growing tendency of the National Health Service and the Industrial Health Service to develop separate entities with little or no co-ordination is unsatisfactory.

Services Will Expand

Rehabilitation services will expand in this country although rather more slowly than some would like; industrial medicine and occupational health will grow perhaps more quickly, under the stimulus of knowledgeable and visionary Ministers of Labour and Health, but they will never be complementary to each other until doctors in the consultant and general practice services fully comprehend what employment or work actually means; what industrial processes demand, and, not least, that work therapy in the actual course of employment can contribute a great deal more to the national economy and the worker's personal happiness than hours spent weekly doing elementary exercises in a hospital physiotherapy department. Nothing is more tiresome than to see the constant reference of people to hospital for exercises which can be done, and indeed are done, in the active performance of their ordinary work, and this wasted time must stop.

The responsibilities of industry are great, because it must be impressed on the curative services of this country that the end result of all their

efforts is work, and work as quickly as possible; the social aspect will follow.

Employers and workers alike must not put barriers in the way of resettlement of handicapped or disabled persons. The limitation of jobs, the demarcation of jobs, the petty differences, the lack of liaison between trade unions in relation to a man's change of job—all these must be overcome in the knowledge that most disabled persons can contribute a full day's work and in the need to return the worker to proper employment and his social environment.

The industrial medical officer has a special responsibility for initiating schemes of liaison within his own establishment. It is part of his normal function, but it is sometimes neglected. Also, he has a most important role in attempting to educate his professional colleagues about the actual performance of processes which are merely named by the majority of doctors, and in the elimination of the term "light work."

The Piercy Committee reported that:—

"Employers can—and in many cases do—take steps to modify the conditions or tempo of employment so as to enable the disabled person on return to employment after illness and injury to accustom himself more gradually to industrial conditions."

Yet there are instances where an almoner has contacted an employer in relation to a person who has had a severe illness or injury and has mentioned "light work". Such a patient usually gets light work, and, in the absence of an industrial medical officer, often remains at the menial task supplied by the use of this archaic term. This fault is not confined to almoners.

Important Statement

The statement made at the seventh World Congress of the International Society for the Care of Cripples by David A. Morse, Director General of the International Labour Organization, is of the greatest importance:

"We all recognize that rehabilitation is not an end in itself, but only a means to an end. Its purpose is to change the disabled person

from a state of dependence to one of independence, from disability and helplessness back to ability and usefulness at work. Resettlement in employment then is the crux of the whole process of rehabilitation."

Historians tell us that one of the greatest achievements of mediaeval Christendom was its success in making work socially satisfying. Nowadays, we seem to have lost the impetus of a faith. By the acceptance of a dynamic philosophy in relation to rehabilitation, we can really make work socially satisfying.

(Continued from Page 9)

Close collaboration of the rehabilitative medical team (doctor, nurse, therapist, social worker) with vocational staff, bringing the placement officer into discussions at hospital level and greater use of existing community services, such as social welfare and public health personnel for this purpose would help avoid the gaps in the management of more severely disabled persons which too often make their full rehabilitation difficult today.

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Rehabilitation **IN CANADA**



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CIVILIAN REHABILITATION

Department of Labour Canada

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CONTENTS

Page

	The International Society for Rehabilitation of the Disabled—Congress
4	The Congress in Retrospect
5	An Evaluation
6	Seminar on Vocational Rehabilitation
11	A Rehabilitation Visit Abroad
13	One Tangible Result
14	Red and Blue Lights and All That Jazz!
	Meeting of the National Advisory Council
19	Report of the National Co-ordinator
20	Developments in Medical Rehabilitation
22	Placement of Disabled Persons
23	Vocational Training for Disabled Persons
24	Vocational Rehabilitation 1962-1963
26	Removing Barriers
28	Older Worker Employment and Training Incentive Program
30	People and Events

This bulletin is prepared by Civilian Rehabilitation, Department of Labour, with the co-operation of the Department of National Health and Welfare, the Department of Veterans Affairs, the National Employment Service and governmental and private agencies interested in the rehabilitation of Canada's disabled.

Let us emphasize—capability—not disability

Let us stress—services instead of support

*Let our objective be—rehabilitation instead of relief and
—training for useful work instead of prolonged dependency.*

Brigadier James L. Melville, Chairman,
National Advisory Council on the Rehabilitation
of the Disabled—Meeting May 1963
Paraphrase of President John F. Kennedy's 1962
State of the Union Message

To Our Readers

DISABILITY: PREVENTION AND REHABILITATION was the theme of the Ninth World Congress of the International Society for Rehabilitation of the Disabled and it embodies the hope and purpose of all who work in this field. Forty Canadians were among the 1,700 delegates and we thought our readers would be interested in the reactions of some of our representatives.

This issue of *Rehabilitation in Canada* also reports on the meeting of the National Advisory Council on the Rehabilitation of the Disabled. This is our national body which reviews the progress of our rehabilitation program and recommends further action.

The plight of older men and women who become unemployed and whose skills are outmoded is a matter of great concern in Canada. In an effort to alleviate the situation the government has initiated a new program to help provide training and employment for these people. Details of the program are outlined in this bulletin.

International Society for Rehabilitation of the Disabled

NINTH WORLD CONGRESS

Copenhagen, Denmark, June 23-29, 1963

The Congress in Retrospect

What are the results of the Ninth World Congress? No one can answer the question at this time. For this reason I say: let us be patient, yet at the same time optimistic. Conditions of Congress work are very much like those of farming: the results of your endeavor will surely appear, but you cannot sow one day and harvest the next.

One thing, however, is quite certain: that the Congress was richly promising as to a profitable development in the field of rehabilitation for the years to come. The overwhelming number of participants and the high quality of the content of the Congress program justify and encourage optimism.

An important phase of the Congress work is still left: the report as to what happened in the Congress. Not only the 1,700 participants from 66 countries who went to Copenhagen but also the thousands of persons all over the world—professionals and others—engaged in rehabilitation problems who could not attend, ought to profit practically and gain inspiration from the Congress. For this purpose the printed proceedings and other reports concerning the Congress will soon become valuable aids which will no doubt be studied intensely everywhere.

Of course, the value of the Congress will be measured only by what happens in the future. The papers delivered and the experiences exchanged will have a meaning only to the extent that the ideas are applied in our daily activities. Till now the Congress has therefore only fulfilled its preliminary mission: to draw increased attention to the problems of the disabled and to the necessity of their solution—through prevention and rehabilitation.

But this is an important step on the road towards more effective future activity. If the increased interest and goodwill aroused by the Congress is kept alive everywhere, results will soon appear. The Congress will also have fulfilled its final mission: having been a lever for progress to the benefit of the disabled of the entire world.

Flemming Grut, President
Ninth World Congress

(Since the proceedings of this congress will be published very soon and will give complete reports of the papers and discussions, we publish here, while they are still fresh in mind, impressions brought back by some of the Canadians who were privileged to participate in the sessions of the Congress and related activities.)

An Evaluation

By Keith Armstrong, M.A., Ph.D.

Executive Director

Canadian Rehabilitation Council for the Disabled

The World Congress held in Copenhagen, Denmark, in June, was sponsored by the International Society for Rehabilitation of the Disabled. This Society is a world-wide organization of national voluntary bodies interested in the welfare of disabled people. Some 65 countries are members. In Canada the Canadian Rehabilitation Council is the affiliated member and contributes to the budget of the society. During the past three-year period Mr. H. H. Popham, Past President of the Canadian Council for Crippled Children and Adults, a well-known Canadian businessman, has been President of the international body.

If one looks at the calendar of events in an international magazine of the many international conventions, congresses and meetings which take place throughout the year, one wonders about the value of the thousands and even millions of dollars which are spent on these events. For anyone who has followed a congress of a particular organization throughout a period of years, the answer lies in two areas. There is no more effective way in which people from different countries, different racial, ethnic, religious and political cultures come together as easily as they do in a congress which is centered around a problem which is of common concern. This is particularly true of the Congress of the International Society where one rarely hears political overtones, religious differences expressed or of a colour distinction made. The centre of interest is in the building of services for people whose physical prowess has been limited by birth, disease or accident.

A second value coming out of the Congress of the International Society is the interchange of information and experiences from leaders in the field of rehabilitation, from many disciplines throughout the world. The leadership of the Congress reads like a "Who's Who" in rehabilitation. One's own point of view cannot help but be enriched through contacts of this calibre. From a personal standpoint, the making of friends in countries throughout the world, friendships which

over a period of time deepen, is a benefit which cannot be easily measured or assessed.

The congresses themselves have gone through a period of evolution since the first meeting some 27 years ago. As the Society itself has grown in stature and influence the work of the organization has come to be centered more and more in the 12 special commissions which form a part of the total organization. These committees and commissions are:

- the Advisory Committee on Arthritis
- World Commission on Cerebral Palsy
- World Commission on Leprosy
- the Committee on Prostheses, Braces and Technical Aids
- the Sub-Committee on the Disabled Home-maker
- the World Commission on Research and Rehabilitation
- the Committee on Social Aspects and Rehabilitation
- the World Commission on Special Education
- the World Committee on Speech and Hearing
- the World Committee on Spinal Paraplegia
- the International Volunteer Service Board
- the World Commission on Vocational Rehabilitation

During the past three-year period Mr. Ian Campbell, National Co-ordinator, Civilian Rehabilitation, has acted as Chairman of the World Commission on Vocational Rehabilitation and the writer has acted in a similar capacity for the World Commission on Special Education.

During the immediate past congress it became increasingly evident that the vitality of the International Society for Rehabilitation of the Disabled and the value of the Congress was centered around the preparatory work which has been done by the commissions over a three-year period.

During the morning sessions general papers were presented. These sessions, however, were not as well attended, nor were their discussions as

valuable, as were the afternoon sessions which were planned and conducted by the committees and commissions. With special reference to the problem of Special Education with which this writer is familiar, a session was sponsored every afternoon and two of these were joint sessions with other committees: first, the Commission on Vocational Rehabilitation and, second, the World Commission on Cerebral Palsy. During the entire week in these sessions standing room only was the order of the day.

Another feature of the Congress which is gaining increasing importance is the meeting of special seminars or training institutes either preceding or following the main congress. During this Congress three such meetings were held. A training course on prosthetics, braces and technical aids was sponsored by the Danish Society. The proceedings from these courses in past years formed a very valuable contribution to the literature in these fields. The second International Seminar on Special Education was chaired by the writer and took place in Nyborg, a beautiful, small city in Denmark close to the birthplace of Hans Christian Andersen. About 80 persons representing 28 different countries met for a three-day intensive consideration of the specific problems surrounding special education. The third special group was

chaired by Mr. Ian Campbell and gave consideration to the problems of vocational rehabilitation throughout the world.

The host society was the Society and Home for Cripples in Denmark. Mr. Fleming Grut was Congress President. He is an architect of international renown who takes an active part at the Board level of the Danish Society and, under his leadership, the program planning and physical facilities provided to the delegates was very effectively handled.

To recount what one derives from a Congress of this nature is a futile exercise when one considers the variety of activity, the breadth of subject matter covered, and the unlimited opportunity for meeting people in all fields of rehabilitation which exists. What one brings away is very personal and depends a good deal on what one is looking for and how actively any particular delegate seeks out the areas which are of interest or profit to him.

Forty Canadians, which is a larger representation than at any previous congress, attended in Copenhagen. I have no doubt in my mind that they share the feeling expressed by many others that, having once been, they would like to have repeat experience and would echo the slogan "Come to Munich in 1966."

Seminar on Vocational Rehabilitation

By Walter N. Boyd,

Co-ordinator and Director of Rehabilitation Services,
Province of Manitoba

Twenty-three countries and four international organizations were represented at the first International Seminar on Vocational Rehabilitation held in Copenhagen in July, 1963, following the Ninth World Congress of the International Society for Rehabilitation of the Disabled. The Seminar was sponsored by the International Society and its member organization in Denmark, the Society and Home for Cripples.

For a proper understanding and appreciation of the importance of the highlights, suggestions and recommendations of the seminar, it would be worthwhile to relate, briefly, the background and functions of the World Commission on Vocational

Rehabilitation.

The WCVR was established in 1960 as a Special Commission of the International Society for Rehabilitation of the Disabled on the vocational aspects of rehabilitation. The Chairman of the Commission is Mr. Ian Campbell, National Co-ordinator of Civilian Rehabilitation, Canada. The chairman, vice-chairman, members and consultants are appointed by the President of the International Society and serve without compensation. Members' appointments are based on their competence in vocational rehabilitation, upon recommendation of the International Society member organizations (60 countries).

The WCVR functions as an integral unit of the International Society and is administered by the Secretary-General. The Commission's staff is headed by a full-time Director.

The WCVR is a non-profit service. Voluntary contributions account for its budget with grants and gifts coming from individuals, foundations, governments, corporations and organizations.

Among the concerns of the WCVR are—
—Employment of the Handicapped,
—Vocational Guidance and Counselling,
—Vocational Training,
—Vocational Selective Placement,
—Sheltered Employment,
—Homebound Employment,
—Rehabilitation in Workmen's Compensation and Social Insurance Programs,
—Prevention of Permanent Disability.

As a specialized group within the total program of the International Society the Commission works co-operatively with other expert commissions and organizations interested in the medical, social and educational phases of services for the handicapped.

In any program which the WCVR undertakes or endorses, it urges the co-operation of all concerned. Every member of the local, national and international community must be solicited for endorsement, support and assistance. Only through the combined efforts of the medical, social, educational and economic groups, both government and non-government, and the community at large, can the vocational rehabilitation program in employment of the handicapped be successful.

The WCVR maintains liaison with world organizations through the International Society's consultative status with the United Nations, the International Labour Organization, the World Health Organization and other such bodies. In co-operation with all these organizations, the primary function of the World Commission is to stimulate and undertake international research in vocational rehabilitation with the purpose of increasing and extending knowledge which will stimulate the employment of handicapped in all countries of the world.

The World Commission attempts to assist local and national programs in obtaining technical assistance and in establishing or developing their vocational rehabilitation services and facilities. A roster of vocational rehabilitation specialists

who have served internationally, and information on possible sources of assistance, is maintained.

The World Commission will assist travelling specialists and students in making contact with vocational rehabilitation centres and programs throughout the world.

When local or national groups are planning special training programs in vocational rehabilitation, the World Commission will assist in contacting instructors and specialists to participate in these training programs.

The World Commission stimulates international and regional meetings on vocational rehabilitation. One such international meeting was the first International Seminar on Vocational Rehabilitation held in Copenhagen this summer.

In his opening remarks, Mr. K. Bundved, Minister of Social Affairs in Denmark, stated: "It is natural that the problems concerning vocational rehabilitation in the various countries must be definitely influenced by the structure of the economy and progress in technical development and administrative traditions. Nevertheless, each country participating in this task is confronted with common basic problems. Many of these common problems come from the fact that successful solution is dependent upon a full understanding of the real meaning of rehabilitation followed by effective co-ordination between many professions, and between government and voluntary organizations."

The following papers were presented by leading authorities from different parts of the world:—"Vocational Rehabilitation in Denmark"; "Co-ordination of Rehabilitation Services"; "Training—for Administrators in Vocational Rehabilitation—for Advisors—for Vocational Instructors and for Supervisory Personnel in Sheltered Employment." Space does not permit the writer to do more than outline a few of the major highlights of this most interesting, stimulating and informative Seminar.

Vocational Rehabilitation in Denmark

Rehabilitation work is carried out by a variety of agencies, by a number of public bodies, by the handicapped themselves through their organizations, and by other voluntary organizations and agencies. It covers widely different fields such as nursery schools, schools, medical treatment,

industrial rehabilitation, vocational training, employment services and residential care. Private initiative has played an important part in many services for the handicapped. In many cases, the state has later assumed the financial responsibility, the cost being paid entirely from public funds, while the institution maintains its character of a voluntary agency, subject to public supervision. In other cases voluntary institutions have passed over to actual state operation.

The Danish Rehabilitation Act of 1960 provides for a country-wide network of regional rehabilitation bodies which do counselling, act as co-ordinating bodies and have wide powers to provide financial assistance for vocational rehabilitation. The responsibilities of the offices include vocational assessment and training or retraining of the handicapped. The offices do not themselves undertake such activities, rather they may arrange for such services to be provided by government or voluntary agencies. The social and vocational counselling service is handled by special rehabilitation officers, of whom the majority are trained social workers. Medical supervisory officers are attached to all of the offices which may also avail themselves of psychiatric, psychological or business consultants. The offices work in close contact with the local employment exchanges. The cost of running the rehabilitation offices is borne by the Exchequer. Any assistance to handicapped persons under the Rehabilitation Act is free of charge. State financing plays a predominant part in meeting the cost of rehabilitation and care of disabled persons in Denmark. Local authorities pay a minor portion of the expenses involved in the operation of special rehabilitation units and of maintenance allowances to persons undergoing treatment.

Danish experience has shown that many handicapped persons require special assistance to meet their occupational problems. The basic view is that training for children and adults alike should, as far as possible, take place under the same conditions as for normal persons. Only where this is not possible does training take place in special institutions. For the handicapped who are not able to obtain or keep employment in the open labour market, provision is made for sheltered employment. The Rehabilitation Act makes provision for the establishment of sheltered workshops.

One of the most significant features about the Danish program is that rehabilitation is not regarded as some kind of a luxury or something special; rather, it is an integral part of the total social security system of the country. This does not mean that voluntary effort has been excluded. There is a close working relationship between government and voluntary effort with voluntary agencies now able to experiment and pioneer in many new areas designed to improve, even further, services and facilities for the handicapped.

Co-ordination of Vocational Rehabilitation Services

This subject elicited a great deal of stimulating discussion. Regardless of the individual differences of countries, it was agreed that co-ordination is a good thing, like good weather. However, there were varying opinions as to the approaches and organizational framework required to achieve effective co-ordination. In spite of the differences of opinion, it was generally agreed that co-ordination must take place at two levels—at the administrative level and at the case, patient, or individual level. The ultimate goal of vocational rehabilitation is to give the handicapped individual an opportunity for social and economic self-realization, to enable him to achieve dignity through his abilities and accomplishments and through employment. It is apparent that vocational rehabilitation is not a thing or a single service such as medical assessment, medical treatment, psychological assessment, social assessment or even participation in a training program; rather, it is a process or a way of doing things. In using the term “rehabilitation” we recognize and appreciate that each handicapped individual is different, that we need to consider his total needs and help him to use his own resources and those of his community in an organized and meaningful way to achieve maximum economic independence.

In every community we have a variety of government and voluntary agencies serving the handicapped. Some are already well developed, while others are still growing. Each of these has its own individual policies and objectives. By tradition, and perhaps for administrative convenience, these resources are vertically structured or program-centered. The individual must fit the program; the program is not designed to assist the

individual in total rehabilitation. The handicapped person requires an individual-centered approach as opposed to a program-centered approach. The vocational rehabilitation program must be horizontally structured and able to span the vertical structured programs in an organized manner. This is not to suggest that one agency or department of government should have within itself all of the resources required; rather, it suggests a co-ordination mechanism to ensure the effective utilization of the services provided by the various groups. This approach accepts the handicapped person as he is at the time of referral, rather than attempting to immediately determine whether he is eligible for this program or that program. Someone must accept responsibility for determining the total problem in co-operation with the many professional persons and agencies that may be concerned. This seems to be the key to all rehabilitation. The alternative situation is well known. The handicapped person is referred from one vertical structure to another. In many instances we see five or more agencies working with the same individual relative to a specific need without any awareness of the individual's total rehabilitation problem, and too often without any awareness of what the other agencies are doing. Such an exercise is not only frustrating to the individual concerned, but is unnecessarily costly in terms of professional time and money.

An effective vocational rehabilitation program is dependent upon co-ordination at the administrative level and at the case level.

Regarding the administrative level, it is imperative that all government and voluntary agency resources in a given community clearly understand the objectives and services of one another. This understanding must be more than just academic, and more than one extracts out of a book on community resources. It must be a working understanding. I believe there are three major requirements for effective co-ordination at the administrative level:—

- 1—There must be one central authority in the community responsible for the rehabilitation of all the handicapped.
- 2—There must be an interdepartmental committee within government composed of the central authority and a senior officer from each of the departments and ministries concerned with vocational rehabilitation.

3—There must be a communication mechanism in the form of a council or committee established by government, composed of representatives from government and the voluntary agencies working on behalf of the handicapped. The central authority should be a member of this group. The function of this council would be:—

- (a) to determine and evaluate the objectives and services of all existing government and voluntary agencies serving the handicapped;
- (b) to develop good lines of communication between existing agencies;
- (c) to determine the need for new services and recommend priority in implementation.

Co-ordination at the case level requires a central authority with such staff as is necessary to provide a case co-ordinating service to the individual handicapped person. The central authority would be responsible for:

- (a) assisting the individual in the development of a realistic rehabilitation objective in co-operation with the individual and all agencies concerned;
- (b) enabling the individual to utilize his own resources in the community in an integrated manner to achieve the planned employment objective;
- (c) follow-up to ensure achievement of the objective or to alter the objective as dictated by changes in circumstances of the individual and his environment.

It goes without saying that the carrying out of an effective and comprehensive vocational rehabilitation service is very complex and requires the utmost in co-operation. There are many well insulated empires and many out-moded concepts which will be difficult to alter.

Training for Vocational Rehabilitation Administrators

The paper presented on this subject concluded as follows:—"The prospective vocational rehabilitation administrators should have training in social work, training in business administration, considerable experience in the counselling of individual vocational rehabilitation candidates, and good leadership qualities including the following

—ability to make good decisions based on knowledge, and to activate people to work with him, control over the situation, ability to assume responsibility, fairness in dealing with other people and the ability to inspire confidence. Vocational rehabilitation is a big and very complex business and it will become more complex in the years ahead. If this is true, then we must ensure that those persons who are going to be responsible for the administration of vocational rehabilitation programs are competent, well-trained, dedicated individuals with high quality leadership characteristics. It is generally agreed that good programs are built on people, not on bricks and mortar”.

The Seminar participants did not all agree that the vocational rehabilitation administrator should be trained in social work. Some even suggested that this might prove to be a disadvantage. Those who agreed with the need for training in social work felt that this training provided the best base for the prospective vocational rehabilitation administrator because the student or apprentice social worker is quickly exposed to the necessity of working with many community resources on behalf of the individual with a rehabilitation or other social problem. They quickly pointed out that training in social work, by itself, does not ensure a competent, effective, vocational rehabilitation administrator. However, if one had to choose a field of professional training which would provide the best base then the field would be social work.

Training for Vocational Instructors

Space permits the writer to deal only with the conclusions of this paper which are as follows:

- 1—A certain system for minimum standards of required qualifications for different vocational teachers and instructors should be developed in each country.
- 2—It is easier to give the necessary teacher training to a skilled worker than to teach the skills to a qualified teacher.
- 3—The vocational instructor should have at least six years' experience in industry as well as basic teacher training for general teachers. The skills of vocational instructors and teachers should be kept up-to-date by visits to industrial establishments in order to keep abreast of new methods and requirements.

- 4—The vocational training instructor who will be teaching handicapped persons, and there are few schools that do not include the handicapped, should have the opportunity of learning about the limitations and capacities of different categories of handicapped persons.

Training for Supervisory Personnel in Sheltered Workshops

An excellent paper on this subject was presented by Dr. A. A. Heering, of the Netherlands, who is a leading international authority on sheltered workshops. One of the major points which came out of his paper was that the supervisory personnel in sheltered workshops should have a good understanding and knowledge of the resources in the community, and the ability to use these effectively. Special two-year courses have been established in the Netherlands to train supervisory personnel. Attempts are made to train the supervisors, not only in production and personnel management, but to give them an appreciation of the limitations and capacities of handicapped persons and of the resources in the community, and how to work with consultants in medicine and social work, etc.

Value of the Seminar

The Seminar was most successful. It provided an excellent opportunity for interchange of information on programs and proposed developments. In the opinion of the writer, it will stimulate appropriate action in all parts of the world to meet more adequately the vocational needs of disabled individuals.

The World Commission on Vocational Rehabilitation plans to conduct a Seminar on sheltered employment in Sweden in 1964 and another Seminar on vocational rehabilitation at the time of the International Society's Third Pan-Pacific Conference in April 1965 in Tokyo.



A Rehabilitation Visit Abroad

By J. A. Carmichael,

Executive Director,

The Society for Crippled Children and Adults of Manitoba

One of the most encouraging impressions to bring back to Canada from the 9th World Congress is that, in general, our rehabilitation programs are developing in the right direction. Throughout the Congress, it was encouraging to note a new emphasis on the individual client as a unique human being, each with his own attitudes and reactions to his physical handicap. Even in the field of industrial accidents we were reminded that, as industry advances in technical safety, we tend all too often to think that all that can be done is done. But we must constantly consider the human error and train continually for its elimination.

Professor Asmussen, of Denmark, voiced a frustration which many of us have at times in this new field of rehabilitation when he said, "If we could only have rehabilitation based on knowledge rather than guesswork." Needless to say this was one of the major reasons for the Congress—to move further in knowledge of rehabilitation. Some of the clinical means of measuring physical tolerance to work, with good correlation with performance at work, were interesting contributions made by participants from Norway and Sweden. Another emphasis on vocational selection was a contribution by the United States of America through the TOWER System of assessment. We were also told again that sheltered workshops did not benefit everyone. This was reassuring to have reconfirmed, especially when you return home to enthusiastic lay members of the community who are quite convinced that sheltered workshops are the answer to all rehabilitation ills and apply pressure to have "bigger and better ones" established. Only when these factors are taken into consideration can each service be established legitimately to give service where needed in the right context.

One of the highlights of the plenary sessions was a panel on the employment of the disabled.

Leaders of international trade unions and leaders of international employers certainly indicated positive attitudes and support to the employment of disabled people. If we persist in our efforts to match the job and the individual our efforts will gain even more respect from these two important groups and this can only lead to results beneficial to those whom we attempt to serve. A speaker from Italy summed this up well when he said, "We must learn how to give back to them their confidence robbed of them by destiny".

Attendance at the International Seminar on Special Education brought emphasis on another aspect of rehabilitation. First of all, I was housed in a students' residence for high school deaf boys. This was a very up-to-date new building and served about 100 boys from the Island of Funen in Denmark. The school had a practical curriculum suited to the needs of the deaf who graduated into productive employment. We have a long way to go in Canada to reach the stage where we take high school education for the deaf for granted. The secret of such success seemed to be in very early training.

Pre-school training for the handicapped is receiving more and more emphasis. It was pointed out repeatedly that the pre-school years were the most formative years of our lives. Therefore, these years must be put to the best possible use for handicapped children to minimize the eventual total handicap any child might have. This is especially true of congenital disabilities such as limb amputees, cerebral palsy, and deafness. These children miss much of the day-to-day activities of normal children with whom they must compete in later life. Therefore, every attempt must be made to fill this gap. This is particularly important in the case of deaf children of pre-school age. For example, a normal child has a vocabulary of about 1,500 words when he enters school at the age of six; the deaf child is fortunate

to have 400 words at this age. Thus if we wish to see deaf children in high school, we must give pre-school training to give them at least a running chance when they begin Grade 1. Since children with physical disabilities can benefit so much, it therefore stands to reason that normal children can also benefit. We are not surprised then to find nursery schools, supported by the public schools system, common in Europe, with children attending as early as age two.

More attention was also urged at this Seminar for early vocational counselling in the schools. It is important to assess the individual early and accurately so that his potential can be predicted and so he can be given training to meet his particular need. All too often the severely handicapped individual is made to fit the curriculum, instead of vice-versa. We were given the illustration of a young boy whose main asset was his manual dexterity. Even though he was severely disabled, training was concentrated on developing his one asset and, by the age of 13, he was sufficiently skilled to earn his living as a tailor. How many of our own schools would have "put him through the educational mill", graduated him with, say, a Grade IX or X with many more years of training ahead before he could hope to contribute to his own upkeep.

A visit to the School for the Deaf in The Hague again showed emphasis on pre-school training. This particular school took three-year-olds on a residential basis allowing the children to go home for the weekend. Little emphasis was placed on parent education. I don't believe many of our North American parents would permit this separation. Our parents are more willing perhaps to "go to school" with these young children of pre-school age and it is on this willingness that we in Manitoba are capitalizing in our new program this fall for the pre-school deaf. Europeans take institutions much more for granted than we do.

While visiting a sheltered workshop in the Netherlands, very close relationships between various government departments and voluntary agencies were apparent. The co-operation seemed so close that during such a brief visit it was difficult at times to separate their activities. There are nearly 200 sheltered workshops in a country which is about 150 miles long and 50 miles wide (an area smaller than our Manitoba Lakes) and supporting a population of 12 million. Employ-

ment is high so there is plenty of work available to the workshops. No specific attempt is made to place clients in open employment. Sometimes clients are hard to find and so not all clients are physically-handicapped, but may be only welfare recipients. Most of the workshops do some form of manufacturing as well as sub-contract work. The cost of the workshop is borne by the federal government to the extent of 80 per cent with the balance made up by local provincial and municipal governments. It is therefore locally advantageous to have a workshop.

During a brief visit to Scotland we found the sheltered workshop situation was quite different. Here there was quite a high rate of unemployment due to a slackness of activity in the shipyards and in the coal mines. Therefore, work for the workshop was more difficult to obtain and there was a long waiting list of clients. I visited what I believe was the only sheltered workshop in Edinburgh, operated by a voluntary agency—the Edinburgh Cripple and Invalid Children's Aid Society—which operates a general rehabilitation program for both children and adults. The government provides a grant equal to about 25 per cent of the budget. The program in this agency has many similarities to the Society for Crippled Children and Adults in Manitoba. I was very interested in their workroom program. This program offers an introduction and preparation to the more disabled for open or sheltered employment. The work in these workrooms is graduated from initial, simple, repetitive jobs with high socialization potential to more complex jobs with less socialization and more job habit-training. This agency considers this program a very important prerequisite to admission to the sheltered workshop.

While in London I was able to visit the offices of the British Council for Rehabilitation of the Disabled which was set up in 1944 for co-ordination and promotion of study, information and research, and which is financed entirely by voluntary subscription. It offers many short educational courses and conferences throughout Great Britain on rehabilitation as a unified service, and on the problems of disease and disablement with particular reference to their bearing on industry. It also arranges, through its Preparatory Training Bureau, courses of correspondence for long-stay patients in hospitals.

It further offers a homebound program with rather a complex voluntary organization throughout Great Britain.

A visit to the Westminster Labor Exchange in the heart of London again brought us face to face with the problems faced by government employment services except that London has more of them. They have their own rehabilitation services within the organization and have elaborate means of channelling large volumes of people into the proper service. I was given a multitude of samples of forms which they use and consider necessary. However, my visit was not long enough to appreciate how they are all used.

Queen Elizabeth Training College was just outside London and proved an interesting visit. The setting was an ideal pastoral one which should make anyone feel good to be in after coming from crowded London. The actual training courses were not in session but, judging from the types of patients convalescing in this physical rehabilitation unit, the disabilities would be fairly severe. I was most impressed here by the work being done by very severely physically handicapped people who lived in residence. The degree of disability was great, in some cases permitting only small hand movements. The main product produced was tiles. The designing, silk screening, painting and firing were done entirely by the various combinations of abilities of the clients. The success of this type of shop, as in many specialty shops, depended solely on the rare abilities, interest and enthusiasm of the foreman.

This was very noticeable time and time again. The success of a specialized program depended on a special individual. This is also common in Canada. What are we learning from this particular type of individual so that we can carry on when they are no longer with us?

One of the last rehabilitation visits was to Remploy, the huge government-sponsored sheltered workshop organization with shops all over the United Kingdom. Our Remploy hosts made us most welcome and our half-day visit was all too brief. The Remploy organization is frequently under criticism, particularly by the voluntary agencies who feel it has become too selective and no longer offers service to those disabled persons who most need it. Nevertheless, they do assist many thousands of disabled people. We visited only one of the workshops where the main sub-contract centred around specialized packaging. This shop was a hive of industry in the midst of a community of small manufacturing. Most of the clients had noticeable physical disabilities, but not extreme. The intake methods appeared sound, and successful attempts were constantly being made to place clients in open employment.

These are some of the highlights of a month abroad. I will continue to benefit from this visit for some time to come. Correspondence has already taken place on rehabilitation problems with acquaintances from other countries made during this visit. I was glad to return to my province and feel more confident in developing and refining the many aspects of our own local program of rehabilitation.

Al-Kafaat - One Tangible Result

Inspired by new knowledge gained during his trip to the World Congress of the International Society for Rehabilitation of the Disabled, Youssef H. Shwayri, of Beirut, Lebanon, a member of the World Commission on Vocational Rehabilitation, upon his return home set about the establishment of a business enterprise (AL-KAFAAT) to give employment to handicapped persons. The first stage was the founding of a leather goods factory with four handicapped workers. The second stage planned is a wood-

working plant and a third stage, to be a watch and precision instrument repair service, will be begun when a student, at present attending the Bulova School in New York, completes his training.

Profits from these enterprises will be used to expand vocational activities, to establish a physiotherapy and brace shop and to provide a grant of five per cent of net profits to the World Commission to help it expand its services for the welfare of the handicapped around the world.

RED AND BLUE LIGHTS AND ALL THAT JAZZ!

By DR. HAROLD V. CRANFIELD

(This paper was delivered by Dr. Cranfield, Consultant Psychiatrist, Hospital for Sick Children, Toronto, at the tenth annual meeting of the Canadian Association of Physical Medicine and Rehabilitation.)

Lumières rouges bleues et tout ça!

Monsieur le Président, Mesdames et Messieurs: Seulement hier, mes amis anglais auraient pu dire: «mais voyons, il ne parle pas français!» et aujourd'hui, mes amis français diront: «dommage, il ne le parle toujours pas!»

Resumé

La pratique entre en conflit avec la théorie en ce qui concerne la valeur relative de l'exercice comparé aux agents physiques dans le rétablissement. Sur vingt manuels analysés, moins de dix pour cent de leur contenu était consacré à l'exercice. Il serait empirique de se prononcer sur base d'observations seulement, cependant par elles, le pourcentage devient renversé. A moins que le néophyte de la médecine physique soit instruit autrement, il va croire ce qu'il lit, bien que ce soit sa propre nécrologie. Il doit réaliser qu'utiliser des dispositifs à cause de leurs avantages psychologiques, fera de nous tous des charlatans, et justifiera la confusion générale de physiatrie avec psychiatrie.

Cependant, je ne veux pas présumer trop de votre tolérance et amitié, et plutôt continuer en anglais, autant pour vous que pour moi-même.

In the Toronto area are 10 psychiatrists. It is proposed to present the views of one of these for your consideration and kindly criticism.

Importance of Activity

A widely-read American weekly contains a section called "Speaking Out" or the "Voice of Dissent". This represents the writer's stand today. He is against the increasing emphasis in the literature upon gadgets and machines in physical therapy departments when it is obvious that exercise is the great restorer. It would be fairer to

say he is "for" the importance of activity for patients. Patients tend to seek the magic cure. If we pretend to offer this, we risk disclosure as a charlatan. We need to restate our belief in what is sound in physical medicine, otherwise it will be drowned in a sea of writing about gadgetry. "Can it be sound and ultra sound at the same time?"

My anonymous associate feels that he is not alone in asking this question. But before his case be stated the area of his experience should first be presented. In the seven hospitals and centres that he attends, there are more than 25 therapists with additional aides. There is in excess of 2,000 beds in these hospitals and his patients range from a few hours to 97 years. Five hundred of these 2,000 patients receive physical treatment. He has not been out of the field of physical medicine in the past 18 years. It is judged that his practice and experience is roughly that of this audience (though you and he are of different vintage). The 50 who practice physical medicine in Canada may have 25,000 people receiving treatment from them.

You are aware of another group, the chiropractors? It is reliably reported that there are 250 in Greater Toronto, and they all seem to be living well. Can it be said that, "Those who treat the obese live off the fat of the land?" In Canada there are 1,200 chiropractors: so they out-number psychiatrists 24 to 1. Numerical strength does not make their practice right and yours wrong. "When one cannot judge what tooth of the buzz-saw has cut the patient's finger one is wiser to fret in silence." So, no matter what number of his many modalities the chiropractor uses on his patient, the quackery would be in attributing the effect in every instance to a manipulative procedure.

The juxtaposition of this reference and the one that follows is not meant to draw a parallel

not only to sound a warning. This week in New York the American Institute of Ultrasonics in medicine is holding its Seventh Annual Meeting. Regner told Upper Canada doctors, a few months ago, that only seven ultrasonic treatment machines are in Britain and that five are permanently under dustcloths. The town of Oakville, where he, whom I represent today, goes to bed at night and rises for breakfast in the morning, has more ultra sonar equipment than the whole of Britain! His doctor's influence is obviously less than Regner's. Ultra sound may have a place, though the Oakville physiatrist has managed without it in his office for a number of years. (But he also sits along without television in his home!) Perhaps he is out of step with the times, for he hasn't learned the "Twist" either, yet he can still do the "Charleston". Do I hear the criticism, "Be not the first by whom the new is tried. Nor yet the last to cast the old aside"?

This physiatrist, looking in his library, found 10 books on physical medicine—they totalled 994 pages. Some 735 of these were devoted to exercise. In physical treatment, does exercise contribute only this 10 per cent to recovery?—is it too old-fashioned to bother writing about? In his case his book shelves didn't offer a proper sampling, he went to the Library of the Toronto Academy of Medicine. The Cumulative Index Medicus 1961 lists only 60 published papers on therapeutic exercise but has 130 on ultra-sonics alone—and this is only one gadget of the many represented in the Index!

Review of Journals

Rounding out the general analysis of literature, a review was made of the Canadian Journals (a) Physiotherapy and (b) Occupational Therapy in the past five years. A quarter of the journals were not available. Of the 75 per cent available, of which all were reviewed, no article referred directly to muscle strengthening. But 50 per cent dealt with techniques and treatment, and only 10 per cent with devices and equipment. At this level of patient treatment, emphasis seems misplaced. It is only where literature is most likely to influence the medical profession itself that there is insufficient attention paid to what concerns the patient.

The therapeutic claims for ultra-sound today read like the claims for long-wave therapy in the textbooks of 30 years ago.¹ There is a dispute of historical significance that one should read. In 1941 Krusen² attacked unsupported claims for short-wave. History repeats itself.

The year 1553, 60 years after Columbus' famed voyage, is the date credited with the first book written by a physician devoted entirely to exercise. It is in Spanish and titled "Libro del ejercicio corporal" or in English, "Book of Bodily Exercise". It is by Dr. Christobal Mendez³. Of three copies of the original book one is in the Yale Library and from it an English translation has been made and published by the Elizabeth Licht Publisher. Exercise warranted a book more than 500 years ago! It is still in style to exercise. George Bernard Shaw got his, walking behind the caskets of friends who exercised unwisely. They had no staying power compared to him. He died at 94.

Perhaps Dr. R. Tait McKenzie⁴ is not familiar to you, as a writer. He died in 1935 but not before he had established his skill in anatomical sculpture. The Scottish War Memorial is probably his best known work. You should remember him as the first professor of physical therapy in North America and the author of a text on remedial exercise.

We are all familiar with Buerger's exercises (described about 1879) which are probably not exercises at all—because the patient remains passive. Don't be guilty of using the expression "passive exercise"! Since the word "exercise" is from the Latin "exeo" "to put forth"—as in "putting forth effort"—and means to "employ actively" it is ridiculous to write a prescription that reads, "passively employ this patient actively". (If one means "passive movement" let one so write!)

Effects of Exercise

Reference is made to Dr. Leo Buerger here because the effects of exercise upon the circulation are very great. Since it is the patient who is to do the exercise he will co-operate best if he knows why he is to do so. Take the time to explain that the circulation^{5, 6}, is a one-way

street, that heart and arteries both pump. Explain that the blood encounters difficulty in returning to the heart against gravity. In the case of the soft-walled vein the pump is outside the blood vessel. It is the skeletal muscle. Only if one be active can he clear his veins of used blood so that fresh blood can easily come down to tissues in the artery, and by way of connecting capillary, reach the vein.

This may seem so elemental as to scarcely warrant reference. But an elementary question put to the late Prof. D. Y. Solandt at our first annual meeting 10 years ago is recalled. The question was, "Where a muscle is denervated, how long should a bout of electrical stimulation be, and how frequently should it be repeated?" He stated that a half-dozen contractions were adequate but that ideally it should be repeated every half-hour. It is judged that most of you follow the fashion of orthopedic surgeons who ask their post-meniscectomy patients to contract quadriceps in drill,^{7,8} 30 times in a bout, and repeat it every hour. This may be 20 unnecessary contractions with an interval of rest twice as long as Dr. Solandt proposed. The physiatrist who is being reported to you, asks his post-operative patients, in hospital, to keep a chart of exercise. It is called the $\frac{1}{2}$ minute $\frac{1}{2}$ hour work-out, and it is 6 to 10 contractions of 3 seconds each repeated every $\frac{1}{2}$ hour and checked by the patient on a chart. (Regular, once daily, progressive maximum resistance exercise is done, as well.)

While everyone knows the importance of muscle action in promoting bone formation, many surgeons neglect to use it. Stimulation of the osteoblast⁹ is a direct result of muscle action! End-to-end compression of bone is obviously occurring constantly in active people, but where there is local inactivity of muscle there is osteoporosis. Dr. Albin T. Jousse has pointed out that weight-bearing in the paraplegic is not a protection against osteoporosis. Osteoblastic stimulation is the end-product of exercise, not of weight-bearing.

The internal architecture of the femur, no less than its external mechanical structure, is faultless, as Koch¹⁰ established in 1917. His description of this is in complete accord with the principles put

forward by Wolff and Roux. Yet we must not be unmindful of the changes in the femur neck found in the elderly and the hemiplegic though each of these persons may be weight-bearing. To protect the neck of the femur against osteoporosis abduction exercise against resistance is essential. Since employing this practice at Our Lady of Mercy Hospital there have been no fresh-fractured femur necks in three years. Before then it was common

This plea for exercise cannot do much more than give reference to a few names from the past and the present who have, and are, contributing to it.

One such name is that of Dr. H. S. Frenkel. You recall that he practised in a time when many cases of syphilis went on to the state of locomotor ataxia. Frenkel wished to supplement the greatly reduced afferent impressions from the dorsal columns—and he reasoned that since these patients staggered more in the dark, to increase ocular stimuli would be effective. It is not useful for the patient with cerebellar degeneration, for the interpretation of ocular stimuli by the damaged cerebellum is no better in that instance than impulses from dorsal or lateral columns.

You know of the Bobath¹¹ technique with the cerebral palsied? It is one of careful positioning to create stability in the patient. He is then gradually released to a pattern of wider ranges of motion as he learns control. It is most effective where the therapist has been trained by the Bobaths themselves. Unfortunately this exposes the therapist to the Bobath's explanations of why the treatment is effective. In-so-far as the disease is one of sensory-motor upset the technique is fundamental and useful. Their explanations seem to come to neither one nor the other. Terms used by Bobath adherents such as "Reflex-inhibiting posture" are distressing to neurologists other than Dr. Bobath himself.

One may pass over reference to Dr. J. B. Menel and to Mrs. Guthrie-Smith, whose brilliant adaptation of principles are invaluable. Each, rightly, is recognized for special equipment found in physical therapy departments. Full help to be derived from Guthrie-Smith springs comes with practice, as our British physiotherapists exhibit competently. Let me hastily state that these gifts are not preferred above our Canadian-trained home-grown product!

Dr. T. L. Delorme

Let us then come to two modern physiatrists—Dr. Thomas Lanier Delorme and Dr. William Smart Tegner. The first of these is known for his many pieces of equipment—the latter for his insistence that we don't need equipment at all!

Tom Delorme was a weight lifter. He came from Alabama and fought the war of Chicago. The American Armed Forces in World War II are reported as giving the Campaign ribbon, the "African Star", to anyone who saw the documentary film "Desert Victory" (the Defeat of Rommel, the Desert Fox). When a group of Canadians first met Tom he had a single year's army service behind him and he was working on his third row of medals. A relative of my wife and son by marriage had five years of campaigning here and abroad, nineteen years of service (rated as undetected crime), and sported two ribbons (1) the "Spam" and (2) the "Away from Mother" (with Star cluster). Tom is built like a weight-lifter—200 pounds on a six-foot-one frame. He is an advertisement for his product. These things are detailed to you only so that you will know that this report is valid and almost first hand. Dr. Arthur Watkins who collaborated with him in his book "Progressive Resistance Exercise"¹² is a New Englander. It is suspected that that is why the warm-up lifts are so precisely described as $\frac{1}{2}$ and $\frac{3}{4}$ of the 10RM (Ten repetition maximum). Any good muscle warm-up will do as long as it doesn't tire the patient physically and psychologically so that he couldn't lift an adequate 10RM. It is a pity that Tom let himself be talked out of using the word "Maximum" in the title, "Progressive (Maximum) Resistance Exercises". It would warn the girls who are our physiotherapists that if Tobin Rote, Cookie Gilchrist or Sam Etcheverry need quadriceps action, 15 lbs. is a silly 10RM. 100 to 140 lbs. might be a more appropriate one for them.

However, throughout 1943 to 1945 many were employing the strength-power increments that come from weight-lifting. That Dr. Andrew M. Zinovieff used one technique in the RAF can be proved from Sir Reginald Watson-Jones' movies. Nick was in them. Unfortunately, he was a "stripping" which mars the impact of the Oxford technique. A somewhat ignored fellow in the RCAF was using yet another at Divadale in Toronto and

it can be attested to by Dr. Gordon A. Lawson. He visited Divadale late in 1945 on his way back from the Mayo Clinic where he had been doing post-graduate study with Dr. Earl Elkins. There are those who have their differences as to technique in progressive maximum resistance exercise! But it would be a great mistake if proponents of exercise should fall to quarrelling. Then the field would be left to the gadget-conscious. It would be a disservice to those who need muscle to be restored.

Dr. W. S. Tegner

And so we come to Dr. Tegner. Many of you heard this brilliant man on a rainy day last fall in Hamilton. He is Chief of Physical Medicine at the London Hospital.

For years a question from an Oakville physiatrist to a new physiotherapist has been, "If limited to one piece of equipment, what would you choose?" The hoped-for answer was, "A gym mat!" (It is useful to lie on when one demonstrates exercise.) It is the sole piece of special, physical medicine, office equipment in one instance of which I am aware. Dr. Tegner says you "catch the brass ring", with him, if your answer to this question be, "A large empty room!" The difference in the answer is perhaps that the effete North American is softened by such comforts as central heating and a flush toilet whose tank can't be brought down by its chain upon one's head.

Nothing has been said of underwater exercise. To this, Lowman, Hansson, Hoke and Baruch have contributed so completely. The great worth of exercise with the aid of buoyancy is recognized. Regrettably, the subject of today can stand no further dilution.

It will be a sorry day, indeed, if that noble expression, "Mens sana in corpore sano", be translated as "An ultra sound mind in a healthy body".

John Dryden in the 17th century gave us this advice:

"Better to hunt in fields, for health unbought,
Than fee the doctor for a nauseous draught.
The wise, for cure, on exercise depend:
God never made his work for man to mend."

It would sound as though Dryden came from Saskatoon and was a member of the Social Credit Party! But he was right about exercise—on it, you can depend!

As was said earlier, in somewhat halting French: "Unless the neophyte to physical medicine be otherwise instructed, he will believe what he reads even though he scan his own obituary".

If you reject out of hand what I have reported to you today then I must content myself with Plato's Republic. In it you will find he said this, "Bodily exercise, when compulsory, does no harm to the body; but knowledge which is acquired under compulsion obtains no hold on the mind".

Summary

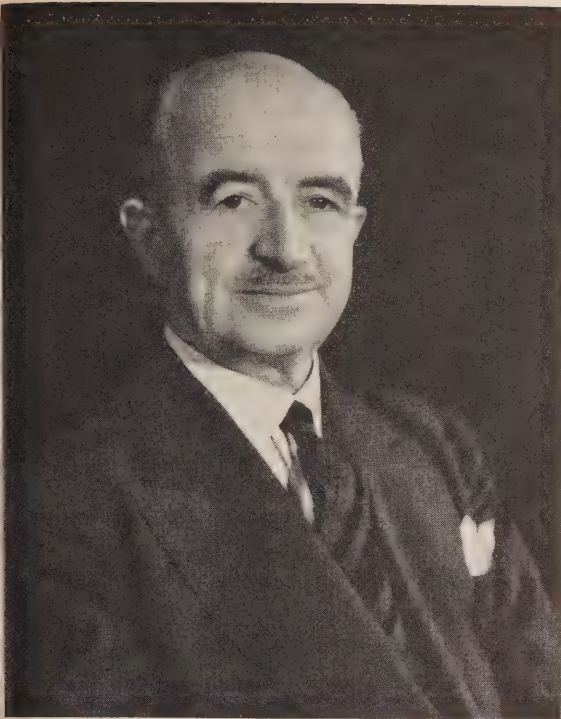
Practice is in conflict with text concerning the relative worth of exercise compared to physical agents in restoration. In 20 textbooks reviewed, less than 10 per cent of their space was devoted to exercise. To report from observation alone may be empirical, yet, by it, this percentage is reversed. Unless the neophyte to physical medicine be otherwise instructed, he will believe what he reads even though he scan his own obituary. He must learn that gadgets used for their psychological advantage will make charlatans of us all and justify the public confusion of physiatry with psychiatry.

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**FOR
ABILITY
HIRE THE HANDICAPPED**



Brigadier James L. Melville, Chairman

Second Meeting

May 13-14, 1963

NATIONAL ADVISORY COUNCIL

on REHABILITATION of the DISABLED

Greetings to Council

Honourable Allan J. MacEachen, Minister of Labour, Canada, welcomed the members of Council and brought greetings from himself and the Honourable Judy LaMarsh, Minister of National Health and Welfare. He assured the Council of the deep interest and continuing support of both departments. Dr. George V. Haythorne,

Deputy Minister of Labour, expressed the appreciation of the Department for the time and effort given by members of Council to the development of a progressive rehabilitation program in Canada. He looked forward to the observations of Council on the matters before it, particularly on the subjects of sheltered workshops and research.

Report of the National Co-ordinator

The past year has been one of organization and planning to assure that all provinces are able to take full advantage of our new comprehensive legislation. Agreements have now been signed with the provinces.

We encountered some difficulty in sharing costs for university training under the terms of the Technical and Vocational Training Assistance Agreements. Program 6 of these Agreements was included to accommodate the Vocational Rehabilitation Program. In the Vocational Rehabilitation and Disabled Persons Act there is no restriction as to the type of training authorized. We have, there-

fore, written to all provinces suggesting an amendment to assure that such training may be given when it is considered necessary. It should be stated, however, that it is not the purpose of a Vocational Rehabilitation Program to give individuals special privileges just because they are disabled. The purpose is to see that these people who are disadvantaged by disability, are enabled, as far as possible, to enjoy the same advantages and assume the same responsibilities as the able-bodied. This objective should be pursued as sensibly and economically as possible. University training, therefore, should only be granted when the

individual has the necessary ability; and when the seriousness of the disability substantially limits his normal opportunities for employment and it is considered that university training is necessary to that person's vocational rehabilitation. To use this provision in any other way would be unfair to those who do not as yet have this privilege. Again, as with all services given, the training should be part of an organized plan to accomplish the individual's rehabilitation.

With the signing of Agreements, the number of staff employed in the provinces has increased from 70 to 140. This is good. Some time must elapse before the effects of this increase are noticeable. The number is not yet nearly sufficient to assure that all of our seriously handicapped can be reached and, also, the distribution of staff across our land is most uneven. We are convinced that the building up of sufficient competent and experienced staff is necessary to make the program really meaningful and to produce the results and effect the savings desirable.

We have kept closely in touch with national voluntary bodies and with international developments. We note that in all parts of the world the philosophy of rehabilitation as a potent weapon

against dependency is being recognized. Canada's experience is being shared with other countries, bringing great praise for our philosophy, our legislation and our emphasis on co-ordination. We have the knowledge and the means to do a good job. Our results still lag quite far behind those of many other nations. However, steady progress is being made and we have every reason to be confident of the future if we all work sufficiently hard and in a co-operative manner.

The effort that is being expended by the staff employed in the provincial programs is tremendous. To quote the brief submitted by the Canadian Welfare Council to the Senate Committee on Manpower and Employment, "The objective should be to ensure that every handicapped person in Canada has the possibility of gainful employment through reasonable access to any rehabilitation measure from which he can benefit. In order to provide these people with opportunities for gainful employment the work of the relevant public agencies must be closely co-ordinated with the efforts of those voluntary agencies and citizen groups which provide services and assistance in these fields".

Developments in Medical Rehabilitation

Dr. O. Hoffman, Chief,
Medical Rehabilitation Division,
Department of National Health and Welfare

The past year has been one of adjustment and reappraisal in the Medical Rehabilitation Division, and we are still faced with problems arising from staff shortage. On the positive side, we were joined in November, 1962, by Dr. K. H. Running in the capacity of Consultant in Physical Medicine and Rehabilitation. Dr. Running is a specialist in physical medicine and has had a wide experience in medical practice and as an Air Force Medical Officer. Dr. Running is well qualified to serve the needs of our Department in his special field, and as time goes on, I anticipate that his work will become widely known.

Three months ago, Dr. Running and I started a series of visits to the various provinces which ultimately will provide us with a comprehensive picture of medical rehabilitation across Canada. We have visited Nova Scotia, Quebec, Alberta

and British Columbia, and even at this early stage of our travels, have been refreshed by some of our observations. The development of medical rehabilitation facilities is encouraging. The concept of Departments of Physical Medicine within active treatment hospitals is gaining wider acceptance, and there appears to be a quickening of interest in rehabilitation on the part of physicians generally.

Health Grants Program

It was stimulating to visit many of the projects receiving Health Grants assistance and to see the tangible results being achieved through the use of these funds.

Expert Committee on Congenital Deformities—The most significant development in the Health Grants Program arose from the problem of the

congenital deformities due to thalidomide. A conference of federal and provincial officers was convened by the Minister of National Health and Welfare in August, 1962 to consider measures to assist with the problems presented by these deformities. The nature of the clinical problem was considered by an Expert Committee convened in the fall by the Department of National Health and Welfare, with representation from the fields of physical medicine, orthopedics, paediatrics, psychiatry, plastic surgery, prosthetics and social work. In November, members of this Committee visited United States centres of treatment for congenitally-deformed children, and a group particularly interested in prosthetic problems has recently returned from a visit to centres in Germany and the United Kingdom. The report of the Expert Committee was tabled early this year, and, among other things, presented a series of fourteen recommendations.

Recommendations of Committee—The Committee pointed out that the congenital deformities associated with the drug thalidomide are essentially similar to those which occur from time to time from unknown causes. It felt that the children should be treated in centres having experience in fitting and training children with all types of amputations. Emphasis was placed on the need for early and continuing treatment of children with limb defects, of whom some 40 per cent require complicated prostheses and the main concern of the Committee was the development of adequate facilities for the treatment of such cases. It was recommended that there be a rapid development of three special training and research centres in Canada, and that a course, conducted by a team of visiting specialists in juvenile amputee problems, be provided to train Canadian teams. The Committee placed particular emphasis on the need for prosthetic specialists in dealing with severe limb defects, and recommended exploration of the whole problem of training of prosthetists with a view to establishing courses in relation to medical schools. Finally, the Committee recommended that the treatment program should be developed within the structure of existing rehabilitation programs, in the best interests of children with abnormalities produced by thalidomide, and to the advantage of rehabilitation programs serving other child amputees.

Implementing the Recommendations—In support of the Committee's recommendations, an additional \$200,000 was voted to the Medical Rehabilitation and Crippled Children Grant early in 1963 for the establishment and maintenance of such research and training units. Health Grants projects have already been initiated to establish these centres. The special course recommended by the Expert Committee is underway in Toronto at the present time (May 1963), attended by teams selected by various provincial governments. The Canadian Medical Association Committee on Rehabilitation has produced an outline of approved courses of training for prosthetists and orthotists in medical teaching centres, and envisages the formation of a national association of prosthetists and orthotists.

These significant developments have come about very rapidly, thanks largely to the efforts of a group of dedicated people, and there is promise that, from the tragedy of children deformed because of thalidomide, may come developments, the benefits of which extend well beyond the area of drug-induced deformity.

Identification of Disabled Persons

In regard to early identification of the disabled there appear to be four main areas to consider in trying to improve the process. These are; through referral by public health nurses especially those in health units; through hospital discharge records; through registries of crippled children and adults; and through referral by private physicians. Taking these in reverse order, an improvement in referrals from private physicians is to a large extent dependent on the education of the medical profession at large. This process of orienting physicians to think in terms of total rehabilitation is going on—slowly perhaps—but there is a definite development of interest on the part of private physicians and medical organizations. The existence of a well-organized rehabilitation process at community level is a major factor in the extent to which early referral from private physicians can be developed.

Registries of crippled children and adults are potential sources of early referral, their usefulness being determined by the nature and objectives of the registry. There are registries in five provinces but their performance and utilization vary considerably. In order to be effective, a high degree of

co-operation is required from a variety of government and voluntary agencies and from physicians.

Public health nurses, both Victorian Order and health unit personnel, are a source of referral—may I say a potentially fertile source. In a survey of health units which was carried out by the Epidemiology Division of our Department, it was indicated that approximately 60 per cent of health units maintained some form of registry of disabled persons. There is a growing recognition of public health nursing responsibility in the rehabilitation process, and, as well, a change in the acknowledged role of health units. In some areas the medical officer of health is a member of the community rehabilitation committee, and the nurses under his supervision take a responsible role in the early identification and treatment of the disabled.

Finally, with reference to hospital discharge

records, it has been suggested that a productive approach might be made through a study of hospital records for information regarding disability status on discharge, and a follow-up of what happens to people who leave hospital with a disability. It seems doubtful, however, that hospital discharge records would be a rich source of information at present. The records would be informative in cases which had entered hospital for the investigation and treatment of a pre-existing disability. However, the records of cases admitted for treatment of acute conditions, or of cases in which a disability was not the primary reason for admission, might leave a good deal to be desired. A research study arranged for a limited period of time within one hospital or a group of hospitals, whereby a comprehensive reporting process might be undertaken for the period of study might, however, prove a worthwhile project if details could be worked out.

Placement of Disabled Persons

C. A. L. Murchison, Commissioner,
Unemployment Insurance Commission

Since 1947 I have been associated, with others, in the challenging task of assisting disabled persons to find jobs in a highly competitive labour market. Prior to that year specialists in this function, in the employment of NES, and other departments of governments and agencies, had agreed that the disabled could be classified into three main groups.

Group 1.—Those whose disabilities were such that they did not require much more than counselling and selective placement techniques, to enable them to obtain permanent employment and so live reasonably normal lives.

Group 2.—Those whose disabilities were such that, with special help in regard to medical and/or psychiatric treatment, vocational counselling, vocational training, social case work services and, finally, special placement, they could compete with the normal person in the labour market.

Group 3.—Those whose disabilities were such that they could never be expected to compete in the open labour market and for whom provision of sheltered workshops or special facilities for home work offered the only form of employment.

I believe that it is fair to say that the foregoing

classifications are as appropriate and valid today as when they were first described. Persons in the first-mentioned group do not require help, save that which is given to them by special services officers. Most of the placements of disabled persons made by NES involved people in this group.

Those of you who are responsible for the rehabilitation program at the provincial level are, of course, more concerned with the people in the second group. Here we find persons who may require medical rehabilitation; they may require expert vocational counselling and vocational training before they can be considered ready for the labour market. NES assists in the determination of the kind of training most suitable for the individual and NES must also use every means possible to place the fully rehabilitated persons in a suitable job, and with the least possible delay. Otherwise the good that comes from the rehabilitation processes would be lost.

You are also concerned with the disabled described in the third group, comprising those who are unemployable in the open labour market. I am pleased to see that discussions are going on

concerning sheltered and vocational adjustment workshops. I hope that discussions on this item will prove to be fruitful, and, further, that in due course an effective program for sheltered employment will be inaugurated.

The sheltered workshop is, in my opinion, a necessary complement to a rehabilitation program, as it provides facilities which will assist the individual to make a more satisfactory adjustment to his living standards and his attitude towards the world of work.

In 1953, the National Committee on Rehabilitation recommended that a survey be conducted for the purpose of ascertaining the educational levels of the disabled. The survey was limited to the Montreal metropolitan area and it showed that 71 per cent of the men and 52 per cent of the women had seven years, or less, of schooling. There is every reason to believe that educational levels of handicapped people in other provinces are about the same as those found among the people interviewed in Montreal. I am advised that some improvement has taken place since 1953, but the educational levels of these people are still far from being adequate.

NES assists in the work of selecting candidates for training under the Technical and Vocational Training Program and it has been found that a substantial proportion of the applicants fail to qualify for the courses because they do not have the academic standing prescribed as a condition precedent to admission. It would seem appropriate to suggest that thought be given to the idea that provision be made for what might here be called

basic training or pre-vocational training. In this way the men and women who are now prevented from taking vocational training, because of lack of schooling, might ultimately come to enjoy the benefits of skills acquired through that training.

Let me say in conclusion that we in the Employment Service know the employment market; we know what industry expects of its employees; we also know that we cannot approach industry with the employment difficulties of disabled persons on the basis of altruism. Actually, there is little room for emotional fervour in the job placement business. Industry is interested in the dollars-and-cents aspect of employer-employee relationships. We can negotiate the sale of a person's services if those services are of the kind and quality required by the employer, and it matters little whether that person is physically disabled.

According to statistics, we promoted quite a few placements of disabled persons last year—20,403 of them. The year before, 18,071 placements were made. The majority of the people referred did not come to us via the provincial co-ordinators. However, the numbers coming to us from the co-ordinators' offices are increasing from year to year. This increase is due largely to the improved liaison established between the local offices of NES and the rehabilitation offices of the provinces.

This comparatively new arrangement with some of the provinces is proving of great value, and there is being developed a team spirit among those directly concerned in all phases of the rehabilitation program.

Vocational Training for Disabled Persons

C. R. Ford, Director,
Technical and Vocational Training

There has been a gradual increase in the number of disabled persons receiving training under program 6 in recent years. In 1961-62, 2,708 (1,660 men and 1,048 women) were enrolled in courses. I am sorry to report that there has not been the usual increase in this number during the last year. The total trained was approximately 2,775 persons, an increase of only 68 persons. I don't for one moment believe that this is a trend. I suspect that the disruption caused in most provinces, by the concentrated effort to

complete approximately a half billion dollars worth of new schools with their equipment, may not have allowed some other things to get their usual attention.

The 135,000 new student places provided by this unprecedented capital expansion program will no doubt create many new possibilities for the training of the handicapped. Many of our new trade schools and institutes of technology have been designed with ramps rather than stairs and with other features built in for the convenience of

the handicapped students.

Educators are becoming increasingly concerned to extend vocational training into new areas, to identify "growth occupations". In a world where technology is eliminating unskilled and labouring work the plight of the physically-handicapped should become less serious. Physical immobility will be less of a disadvantage. On the other hand, the opportunities for the mentally-handicapped will be reduced.

The lack of basic education is becoming a most serious handicap even for those who do not fall within the category of disabled. It is therefore fitting that consideration be given to the possibilities of "basic training for skill development" programs to open the door to more demanding vocational courses.

Training-on-the-job, if arranged with due care and consideration, seems to be playing an increas-

ingly important part in Program 6 endeavours. During the last fiscal year 339 T.O.J. contracts were approved. This method has several advantages over in-school training for many rehabilitation cases, i.e., the involvement of industry and the opportunity for early assessment in the job situation. Selection, however, must be done very carefully to avoid the estrangement of "the geese which lay the golden eggs"—the employers. T.O.J. has the added advantage of pretty well solving the placement problem.

There are indications that industrial workshops are not confined to sheltered employment and may, in fact, provide suitable occupational training in some instances. We also note that there is a growing interest in the rehabilitation of those who have suffered from mental disease. "Work training" can be used to reawaken in them the motivation and habits needed for employment.

Vocational Rehabilitation 1962-1963

The year 1962-63 was marked by the negotiation of new Agreements with the provinces under the terms of the Vocational Rehabilitation of Disabled Persons Act which became effective April 1, 1962. Under the stimulus of this new legislation all provinces have been reviewing their programs, examining their services and looking to the further expansion and co-ordination of all those services needed for an effective program. This is reflected in the increasing number of cases reported by the provinces on which it has been possible to obtain complete details. These reports are completed at the time when active rehabilitation services have terminated and a suitable period of follow-up has revealed that these individuals have reached definite "rehabilitation status".

Status after Rehabilitation

A total of 1,814 such reports of rehabilitated persons was received from the provinces in 1962-63. It is noted that, of this number, 1,366 became regularly employed in business and industry; 87 set up in business for themselves in such occupations as watch-repairing, shoe-repairing, barbering and hairdressing; 62 became employed in sheltered employment; 24 were enabled to undertake some homebound employment and 151 of the severely disabled were helped to the place where

they could undertake their own care. One hundred and twenty-four resumed their responsibilities as housewives and homemakers.

Services Provided

In addition to medical, social and vocational assessment and counselling, a variety of treatment services were provided to more than half the number of persons rehabilitated and almost 300 were fitted with prosthetic appliances and devices.

Economic Factors

In reviewing the economic factors involved we find that of the total 1,814 persons, over 68 per cent were dependent on relatives or public assistance and that there were 1,400 dependents involved. The cost to the public purse is estimated to be \$1,118,891 annually. Following rehabilitation, the estimated total annual income for the group is in the neighbourhood of \$3,401,979. The contribution of the housewives and homemakers is in addition to this total.

Education and Training

A study of the educational qualifications shows that 988 persons had not gone beyond elementary school, with 170 having less than grade four education. Only 39 had continued their education

beyond high school but 346 had had some vocational training. In carrying out their rehabilitation plan, 810 undertook vocational training for various occupations. These included a variety of trades, service occupations such as hairdressing, barbering, nursing assistants and orderlies, shoe-repairing, and business and office work. Over 50 received training as nurses, teachers and in technology.

Before and After Rehabilitation

Prior to their acceptance for rehabilitation services, 560 of these individuals had never been employed; 332 had been employed as unskilled workers; 118 were in semi-skilled occupations and 158 in skilled occupations. One hundred and eighteen were engaged in agriculture, fishing or forestry. Service occupations gave employment to 50 and 208 were employed in sales and clerical work with 51 in the professional or managerial field. One hundred and seventeen had been housewives or homemakers and two were retired from employment.

With rehabilitation complete, the reports indicate that 114 are now employed in the professional or managerial field; 457 in sales and clerical work; 299 in service occupations; 68 remaining in agriculture, fishing or forestry; 201 as skilled workmen; 154 semi-skilled and 246 in unskilled work. The remainder are housewives or homemakers.

Age and Sex

The age distribution of these disabled individuals extends from youth to old age with over 10 per cent of them under 30 years of age, many of them new entrants into the labour market. It is worth noting, however, that almost 30 per cent of those rehabilitated are over 40 years of age. Women form just under one-third of the total.

Types of Disabilities

The persons involved suffered from a wide variety of disabling conditions. Over 28 per cent had conditions which interfered with the effective use of their limbs, 292 were deaf or hard of hearing and 149 were blind or had severe visual defects, 239 had neuro-psychiatric disorders and 32 had tuberculosis or other respiratory involvements, 149 had neurological conditions and 116

were amputees. Sixty-eight had cardio-vascular conditions and the remaining 62 suffered from various other disorders.

1957-1963

This brings to 9,789 the number of such cases reported since the beginning of the federal-provincial rehabilitation program in 1957. It is estimated that, without rehabilitation assistance, these persons, with their 7,435 dependents, were costing \$6,530,386 annually for support. Now they earn approximately \$18,000,000 a year and they have accumulated a total of \$63,237,352 in earnings since they became employed. This contrasts with the cost of their support for the same period which would have been almost \$24,500,000.



A Training Program for Retarded Young People

The Training School for Retarded at Prince Albert, Saskatchewan, which was opened on July 1, 1961, is set in an evergreen forest surrounded by an extensive lawn. It has accommodation for approximately 200 male and 100 female trainees.

About half of the trainees are taking part in industrial work or training, one quarter are employed in a service work program while the remainder are engaged in socialization activities.

In the industrial program articles such as wooden clothes drying racks, waste paper baskets, kindergarten furniture, snow fencing and lawn chairs are manufactured and sold to retail outlets on the same basis as any manufacturer.

The Prince Albert Training School is planning an experimental agricultural project.



REMOVING BARRIERS . . .

NRC Committee to draft Supplement to Building Code

Getting in and out of buildings can be a major problem to disabled or older persons. When architectural design provides long flights of steps, narrow doorways and other obstructing features, persons with ambulatory difficulties—those on crutches, in wheelchairs, persons with heart conditions, many of our older population—find it difficult if not impossible to pursue a normal course of life in the community. As a child or youth such a disabled person has difficulty getting a proper education, not through lack of ability or intelligence but through inability to ascend a flight of steps to school. He cannot use the facilities of the public library, he is prevented from enjoying and participating in the activities of his church, he has difficulty in finding or holding a job not because he is not capable but because of the inadequacies of the building where the job may be found: In some cases, he cannot get to the employment office for similar reasons. His whole life is restricted. In many cases his difficulties could be eased or eliminated by minor adjustments that would not interfere with normal use but would rather be a convenience for all.

If we can correct the difficulties imposed by building design we will make it possible to use the talents and resources of many disabled and older citizens for the betterment of our whole economy.

How Big is the Problem?

The results of the Canadian Sickness Survey of 1951 indicate the number of persons in the population who suffer from disabling conditions. It is estimated that there are more than 1,250,000 persons with some measure of disability and almost 2,000,000 persons over 60 years of age, many of whom would benefit from easier access and use of homes and public buildings.

How to Meet this Problem?

In an endeavour to find a way to cope with this problem a meeting was called in Ottawa on September 5, 1963, at the Division of Building Research, National Research Council, to consider the desirability of preparing a supplement to the National Building Code outlining ways of making buildings usable by persons with impaired physical function. Representatives of voluntary agencies, government bodies and professional groups concerned with this problem attended from all parts of Canada.

National Building Code

Dr. R. F. Legget, Director of the Division of Building Research, National Research Council, outlined the purposes of the National Building Code and how it was prepared. He recounted the steps taken to keep the National Building Code

up to date with new developments.

As explained by Dr. Legget, the building code is published under the direction of an associate committee on the National Building Code composed of about 24 Canadian citizens appointed by the Council. It is an advisory document for use throughout Canada. It has no legal standing unless and until it is adopted by a provincial government or municipality. It is essentially a set of minimum regulations respecting the safety of buildings with reference to public health, fire protection and structural sufficiency. Its essential purpose is the promotion of public safety through the use of desirable building standards throughout Canada.

Concern of Government Departments

G. W. Peck, of the Hospital Design Division, Department of National Health and Welfare, became involved in this project through departmental concern that hospitals should be designed to be accessible to all. There had been consideration of publication of a Guide for Hospital Building Standards. This has now been referred to the National Research Council.

Ian Campbell, National Co-ordinator of Civilian Rehabilitation, spoke of the interest of the Department of Labour, which is concerned with the effective utilization of manpower. Disabled persons have many skills and talents and it is essential for their own well-being and the well-being of the country that they be enabled to make their contribution. Sometimes simple adjustments to buildings or machinery is all that is needed to enable a handicapped person to function successfully. Experience has shown that, when steps have been taken to make buildings more readily accessible and useful for handicapped persons, other persons quickly appreciate and make use of the improved facilities.

Ideas and Suggestions Presented

Dr. M. G. P. Cameron, of the University of Saskatchewan, told of the program carried on in that province which has resulted in action being taken in a number of instances to include ramps and seating accommodation for persons in wheelchairs in churches, libraries, a hockey arena and at the new university campus in Regina.

Isidore Weltman, representing the Handicapped Rehabilitation Association, presented a number

of specific requirements to facilitate the use of buildings by persons with physical limitations.

A lively discussion period, to which everyone contributed, produced many useful ideas and suggestions for future action.

Recommendation

It was the unanimous decision of the gathering that the Associate Committee on the National Building Code be asked to authorize the preparation of a supplement to the National Building Code to contain essential and desirable requirements to be incorporated into buildings to make them usable by people with handicaps and aging persons.

NOTE: This project has now been approved by the Associate Committee and a working committee has been established to proceed with the preparation of such a supplement. Ian Campbell, National Co-ordinator, Civilian Rehabilitation, has been named chairman.

Crippled Children's Camp Commemorates Anniversary

August 14 1963 marked the twenty-fifth anniversary of the founding of the Crippled Children's Camp at St. Alphonse, Joliette Co., Quebec. The event was under the distinguished patronage of the Honourable Alphonse Couturier, M.D., Minister of Health for the province. The campers entertained their visitors with an exhibition of square-dancing in wheelchairs, aquatic-ballet and musical numbers provided by the choir and orchestra. Theatre sketches were presented and an art exhibit was held. The visitors were guests at a buffet dinner to conclude the festivities.

Changes in Course at U.B.C.

The combined course in Physical and Occupational Therapy at the School of Rehabilitation Medicine at the University of British Columbia will become a four-year degree program, with internship periods in hospital.

The change provides that after the third year internship, students may qualify for membership in the Canadian Association of Occupational Therapy and/or the Canadian Physiotherapy Association, and then be eligible to practise in either profession, or they may return to the University and complete the fourth year for the Bachelor of Science in Rehabilitation degree.

OLDER WORKER EMPLOYMENT AND TRAINING INCENTIVE PROGRAM

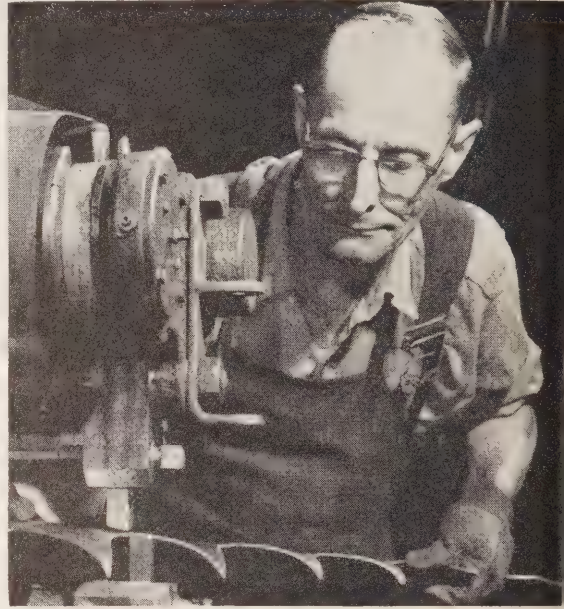
Government introduces new program to help older men and women
to secure employment

For several years, the National Employment Service and the Department of Labour, through its Division on Older Workers and its Information Branch, have co-operated in educational efforts designed to discourage age discrimination in employment. These efforts have been ably supported by the press, outdoor advertising companies, social welfare agencies, and labour and management organizations.

These combined and co-operative forces, working to remove unjustified prejudice against the older worker, have been beneficial and have produced lasting results. In recent years, more and more employers have been utilizing the services of older workers and recognizing their special qualities such as, mature judgment, knowledge gained from experience, stability, lower absenteeism, lower labour turnover and accident rates.

The social and economic problem of the older worker, while only one of the many problems of aging, is becoming more widely recognized as one of the most important. Those familiar with the field of gerontology fully realize that the social, psychological, welfare, housing and health problems of the 65-and-over group are aggravated when adequate economic security is lacking. Those who are steadily employed for the 15 to 20 years prior to retirement are likely to build up adequate economic security for the later years thereby making their adjustment to retirement easier. It is, therefore, essential to develop and encourage the employment of the 40-65 age group.

The duration of unemployment for workers over 45 is generally much longer than for younger workers. In many cases their skills have become obsolescent and they suffer long periods of unemployment because their age and lack of modern industrial experience make their re-entry to the labour market extremely difficult. The longer they are unemployed, the lower sinks their morale and self-confidence, until a point may be reached



where they are regarded as unemployable. Even employers who are favourably inclined toward hiring older workers find it difficult to hire them when they lack the necessary occupational qualifications to fill vacancies in modern industry.

It is usually in his forties or fifties that a man's family and community obligations are at their highest. His children are of high school or college age with the financial commitments such educational activities entail. Little imagination is required to understand the serious consequence upon such a family when the middle-aged bread winner is unemployed. Even when he succeeds in obtaining employment he frequently suffers a downgrading in status and wages.

In order to assist long-term unemployed mature men and women to secure gainful employment and upgrade their occupational qualifications the Canadian Government has introduced a special program.

This project, called the "Older Worker Employment and Training Incentive Program", involves incentive payments to employers who hire eligible older workers between November 1, 1963 and January 31, 1964. The payments amount to 50 per cent of the monthly wage paid or \$75.00 per month, whichever is less. Incentive payments are continued for a total period not exceeding 12 months.

An eligible employee must have been working for the employer for three months before the first claim for payment can be made. When the employer's claim is approved, he receives wage reimbursement retroactive to the date of hiring and monthly payments for the remaining nine months.

Conditions governing payments to employers are as follows:

1. Incentive payments apply only to employment which is insurable under the Unemployment Insurance Act, excluding employment by governments at all levels and by government-owned business enterprises.
2. The employer must provide the worker with a significant amount of approved on-the-job training or, if this is inappropriate, other approved programs to assist the worker to continue in gainful employment.
3. The employer must hire the worker during the period November 1, 1963 to January 31, 1964 and employ the worker or his eligible replacement for three months before the incentive becomes payable.

4. The worker must not be employed in a job vacated by another worker after September 1, 1963.

Conditions applying to the eligibility of workers are as follows:

1. The worker must be 45 years of age or over and not in full-time employment at the time of hiring.
2. The worker must not be eligible for regular unemployment insurance benefits.
3. The worker must have been unemployed for at least six of the previous nine months. Evidence of unemployment can be provided by registration with the National Employment Service, receipt of unemployment assistance payments or other satisfactory evidence of attachment to the labour market.
4. The worker must not be in receipt of the universal old age pension or any other retirement or pension benefits equivalent to, or higher than the universal old age pension.
5. The worker must be the only member of the family household for whom an incentive payment is made.

Local offices of the National Employment Service receive applications from both employers and workers and decide on the eligibility of both job vacancies and workers.

The role of the Department of Labour in this new program is general promotion and the development of co-operative relationships with provincial departments, rehabilitation agencies and other interested groups.



People and Events

"Employ the Handicapped Week" in Montreal

Reports from Montreal indicate that a highly successful "Employ the Handicapped Week" was held from May 5 to 11 with 578 handicapped workers referred to employers by special Service Officers during that month and 368 placements confirmed by employers.

Maple Leaf Potato Chips Inc., which hired 15 handicapped persons during the Week to operate processing machines was declared the outstanding employer of the Week.

"Rehab-Showcases"

"The handicapped are a good employment risk" says Stan Cassidy of Fredericton, New Brunswick, and he backs his belief with action. He has already established two service stations in the province which are operated by handicapped persons. Mr. Cassidy is planning to open four more such stations in the province.

He calls his project "Rehab-Showcases", an indication of his wish to demonstrate to others that the disabled make good workers. He hopes that it will encourage other businessmen to develop similar business enterprises in line with their own experiences and interests which will extend employment opportunities to disabled persons.

Stan Cassidy was one of the prime movers in the establishment of the Forest Hill Rehabilitation Centre and serves as chairman of its Board of Directors.

A Success Story

Two youths who were trained under the program of the Windsor Association for Retarded Children are now steadily employed at the K. Mart store in that city. The boys were hired originally as temporary help to tag merchandise but so well did they prove their worth they have been taken on the permanent staff. They are now doing a variety of tasks, including varnishing shelves, building display steps, bringing up merchandise, and sweeping. When they had earned as much as they were allowed to make and still retain their disability pensions, their parents agreed that they should relinquish their pensions to take the steady

positions offered them. They are treated in the same way and paid at the same rate as the other employees at the store.

The situation seems to be a happy one from every angle. The store manager is happy with the boys' work, the boys are in Seventh Heaven earning so much money and the staff of the Training Centre have reason to be proud of the fine job they have done in training the boys.

Ivan Harrison and Roy Washington are proving to the community that a retarded adult can be a useful member of our society.

John A. Nesbitt



John A. Nesbitt, M.A., Director of the World Commission on Vocational Rehabilitation for the past three years, has resigned to accept a position with the International Recreation Association.

Mr. Nesbitt has done an outstanding job in organizing and carrying on the activities of the Commission and has become well-known in the international field. Rehabilitation workers everywhere will regret his decision to leave the Commission but will wish him every success in his new post.

Hemophiliac Federation Established

Of interest to hemophiliacs was the establishment of the World Federation of Hemophilia during the meetings of the Ninth World Congress in Copenhagen. The purposes of the Society are: to help hemophiliacs, and those with related disorders, in every way possible, and to provide fellowship to all concerned with hemophilia throughout the world; to stimulate interest in the development and improvement of diagnosis, treatment, rehabilitation and research in hemophilia; to serve as a co-ordinating body to develop the collection, distribution and exchange of information on hemophilia and related disorders; to encourage the foundation and development of hemophilia organizations in all countries.

Membership in the organization is open to national hemophilia societies and to individual members.

A number of representatives from Canada attended the organizing meeting when Frank Schnabel, President of the Canadian Hemophilia Society, was appointed chairman. Dr. Cecil Harris, Consultant to the Canadian Society, was one of three medical secretaries appointed to serve the new federation.

Dr. J. W. Willard Receives Award

Dr. Joseph W. Willard, Deputy Minister of Welfare, Canada, was honoured during 1963 by the Baron de Hirsch Institute of Montreal, with an award for "dedicated service in the cause of human welfare". The award was made in connection with the Institute's celebration of 100 years of welfare services to Montreal's Jewish community, a service which has grown over the years into a comprehensive agency offering professional welfare, medical, legal and other services.

Dr. Willard, Deputy Minister of Welfare since 1960, served as Director of the Research Division of the Department of National Health and Welfare from 1947. He has played a major role in the development of such programs as National Health Grants, Old Age Security, Disability Allowances, Unemployment Assistance, Hospital Insurance, National Welfare Grants and the Fitness and

Amateur Sports Program. (Medical Services Journal—June, 1963)

Dr. Willard has always taken an active interest in rehabilitation and has been of constant help as the program has developed in Canada—Ed.

C. Lethbridge, Rehabilitation Leader, Dies

Canada has lost a leader in the field of rehabilitation work through the sudden death of Miss Constance Lethbridge, executive director of the Occupational Therapy and Rehabilitation Centre in Montreal since 1951.

Miss Lethbridge was a native of Winnipeg and a graduate of the Winnipeg General Hospital. She served in various administrative capacities in nursing until she went to Montreal in 1940 to take social work training at the McGill School of Social Work. In 1944 she joined the staff of the Family Welfare Association (now the Family Service Association), becoming supervisor of the south district in 1947.

A member of the adult section of the Canadian Rehabilitation Council for the Disabled, she was chairman of the Council's conference last October in Ste. Adele, Que., on the need for sheltered employment.

Canadian Film Receives Award

The film "Stepping Stones" was awarded third prize in Category B (Social Problems) at the International Labour Film Festival held in Belgium in May 1963. A print has been placed on file in the film library of the International Labour Film Institute in Brussels.

"Stepping Stones" is a colour documentary depicting how an injured workman responds to treatment, regains his confidence in spite of his handicap and is able to make necessary mental adjustments and return to work. The film was made almost entirely at the Hospital and Rehabilitation Centre of the Ontario Workmen's Compensation Board at Downsview.

Copies for showing to interested groups may be obtained from the Public Service Division, Workmen's Compensation Board, 90 Harbour St., Toronto 1, Ontario.

Rehabilitation Offices In Canada

NATIONAL OFFICE

National Co-ordinator,
Civilian Rehabilitation,
Department of Labour,
OTTAWA, Ontario.

PROVINCIAL OFFICES

Provincial Co-ordinator of Rehabilitation,
Department of Health,
Post Office Box 5250,
ST. JOHN'S, Newfoundland.

Deputy Minister,
Department of Welfare and Labour,
CHARLOTTETOWN, Prince Edward Island.

Provincial Rehabilitation Co-ordinator,
Department of Public Health,
Post Office Box 488,
HALIFAX, Nova Scotia.

Director and Co-ordinator of Rehabilitation,
Department of Health,
FREDERICTON, New Brunswick.

Physically Handicapped Division,
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MONTREAL 11, Quebec.

Provincial Co-ordinator of Vocational Rehabilitation,
Department of Public Welfare,
85 Eglinton Avenue East,
TORONTO 12, Ontario.

Provincial Co-ordinator of Rehabilitation Services,
Department of Health,
Kennedy & York,
WINNIPEG 1, Manitoba.

Provincial Co-ordinator of Rehabilitation,
Health and Welfare Building,
REGINA, Saskatchewan.

Provincial Co-ordinator of Rehabilitation,
Department of Public Welfare,
109th Street and 98th Avenue,
EDMONTON, Alberta.

Rehabilitation Co-ordinator,
Department of Health Service and Hospital Insurance,
828 West 10th Avenue,
VANCOUVER 9, British Columbia.

BLIND WORKERS HIGHLY RATED BY EMPLOYER

Lack of "normal" vision is no handicap for blind or partially sighted personnel employed by Mortifee Munshaw Ltd., Vancouver—Canada's longest established and most complete film processing laboratory. Far from it, because the people know that they can do their jobs better than others, and have the personal satisfaction in being aware that their employers know it too.

It all started about 5 years ago, when Mortifee Munshaw were approached by C.N.I.B. placement officers investigating new employment opportunities that might be discovered on behalf of individuals they desired to rehabilitate. The firm's past record for open mindedness and progressive thinking made them a logical prospect.

Initial discussions appeared to indicate that an experiment by Mortifee Munshaw was justified and a selected candidate was taken on as an apprentice, to train under an experienced darkroom worker. Color film processing is a critical business, with the most critical stage being performed in total darkness. Extreme care must be taken in handling film at this stage, to ensure proper racking procedures, to prevent abrasion, finger prints, physical damage, etc. Within a very few weeks the "apprentice" was doing this job better than his teacher, and a short time later assumed full charge of this function, plus taking over the project of training other C.N.I.B. candidates as assistants.

Mortifee Munshaw now employs four full time blind employees—two men and two women—with a fifth engaged for the busy spring, summer and fall seasons to help out. These capable people are now busily occupied, at the same pay scale as sighted people, in charge of film processing, motion picture splicing, and spooling miniature film.

Do Mortifee Munshaw consider these people handicapped? Certainly not! Company officials express real pride in these employees, pointing out that being free from the feeling of confinement that lack of usual light brings to others, they set new standards for cheerfulness, capability and devotion to duty, which does a lot to maintain the Mortifee Munshaw slogan "From Coast to Coast—Canada's Standard of Quality".



Rehabilitation **IN CANADA**



published in the interests of Canada's Disabled by ...

CIVILIAN REHABILITATION

Department of Labour Canada

ISSUE No. 7

CONTENTS

Page

- 4 Training of Vocational Rehabilitation Counsellors
- 9 What of the Epileptic?
- 11 World Congress 1963—I.S.R.D.
- 13 "The Boat to do the Job"
- 17 Medic-Alert Foundation
- 19 Expansion in Sheltered Employment
- 20 New Developments At Manitoba Rehabilitation Hospital
- 21 The Handicapped—When Can He Work?
- 22 People and Events

This bulletin is prepared by Civilian Rehabilitation, Department of Labour, with the co-operation of the Department of National Health and Welfare, the Department of Veterans Affairs, the National Employment Service and governmental and private agencies interested in the rehabilitation of Canada's disabled.

*"If we were to apply the same qualities of imagination,
initiative and earnest endeavour to humanity's social advancement
as are being applied to the conquest of space, then the needs
of the disabled throughout the world could be met"*

Ian Campbell, National Co-ordinator,
Civilian Rehabilitation, Canada,
Chairman, World Commission on
Vocational Rehabilitation in message to
Pan-Pacific Seminar on Vocational Rehabilitation
of the Disabled

To Our Readers

The early identification of persons with substantial residual disability and their prompt referral to vocational rehabilitation services is a matter of vital concern to a successful rehabilitation program. This question was discussed at length at the last meeting of the National Advisory Council on the Rehabilitation of Disabled Persons. In a vast country like ours, there is no one way to carry out case-finding and a variety of methods are being used. Newfoundland, with problems peculiar to itself, has developed a program, both imaginative and practical, to seek out disabled persons in the remotest hamlets and outports to give them the opportunity to receive those services that may help them towards independent and satisfying lives. This issue includes an eyewitness account of the Newfoundland plan in operation.

The equally important need for well-trained personnel in the program is emphasized in an article which outlines some of the requirements of rehabilitation counsellor training.

Included also is a further report on the World Congress of the International Society for Rehabilitation of the Disabled.

TRAINING OF VOCATIONAL REHABILITATION COUNSELLORS

By

VALERIE A. SIMS, *Rehabilitation Assistant,*

Civilian Rehabilitation, Department of Labour, Ottawa

The shortage of qualified personnel in the face of a rising demand for more and better services is as much a problem for vocational rehabilitation as it is for the social services generally. Public responsibility and limited availability of personnel require that the best use be made of available staff. Opportunities should be provided for developing and maintaining skill and knowledge. The task of recruiting and training staff is perhaps a problem of even greater proportions than finding the money to pay salaries.

Staff Training as Part of Program Development

The passing of the Vocational Rehabilitation of Disabled Persons Act in 1961 endorses vocational rehabilitation as the most effective approach to the problem of the social and economic consequences of disability. It should encourage an expansion effort to bring the availability of rehabilitation services into a reasonable approximation of the need. This would require development of both the provincial government vocational rehabilitation programs and of the services necessary for rehabilitation which are provided through other community agencies and resources. Expansion and improvement of services is necessary to meet the demand which is growing as the effectiveness of rehabilitation becomes more widely appreciated. At the same time, it is essential that, as services develop, there be a corresponding improvement in their availability to disabled persons. This is not something which happens automatically. There has to be a deliberate effort to devise more effective arrangements so that services which are required to help disabled people are known and may be made use of with the minimum of delay and red tape. This implies good co-ordination at all levels, that administrators be sensitive to the best ways of meeting the needs of the people their programs

are designed to help, and that rehabilitation case-workers and counsellors possess a knowledge of rehabilitation resources and how to use them, as well as the skills to understand and help their clients appropriately and constructively. Expansion of program is therefore more than a matter of increased operating funds, it is a question, too, of quality and use of personnel, availability of services and organized co-operation among services.

Staff of the Program

The size of the staff employed in the federal-provincial vocational rehabilitation program has doubled since the passing of the Act and continued increase is to be expected. The necessity for providing training for this staff is recognized in the Vocational Rehabilitation Agreements with the provinces. Under the Agreement the federal government will share with the provinces the costs of "training persons as counsellors and administrators to carry out the provincial vocational rehabilitation program". This provision includes staff persons employed in the provincial programs and also in agencies and organizations designated by the provinces to carry out a particular aspect of the program. Training may be arranged through appropriate courses in schools or universities, by the organization of seminars, workshops or short courses, or "by using such means as are deemed necessary for the development of high standards and an orderly process of on-the-job training."

There are about 85 vocational rehabilitation counsellors or officers with rehabilitation case-loads working directly within the Federal-Provincial Vocational Rehabilitation Program. Just over 70 of these are full-time and the remainder are engaged in part-time vocational rehabilitation counselling. About 60 are working in public departments of health or welfare in the provinces and the rest are employed in the "designated" voluntary agencies.

This staff provides direct services to rehabilitation clients. In addition there are nine provincial co-ordinators of rehabilitation, some of whom have administrative and consultative personnel on their staffs. There is also supervisory personnel supervising the counsellors, about five full-time and ten half-time, within the federal-provincial program. In two provinces, the duties of program director are distinct from the duties of co-ordinator and in addition to these two directors, there are three positions of program supervisor; one in a public department and two in voluntary agencies. Finally, there are three full-time psychologists. In all there are almost 140 persons working directly in the federal-provincial program who would be involved in staff training and development. In addition to this group, there is a larger group of persons, including medical consultants, social workers, nurses, workshop supervisors, psychologists and others closely associated with the program, although attached to other agencies or departments. As the program is a co-operative one relying on the services of all these other agencies, staff training and development planning should also take their needs into account.

Expansion of Training Opportunities Based on Experience

Staff training activities had, of course, been carried on in the vocational rehabilitation program before the passing of the legislation, with federal cost-sharing and co-operation in planning through the Civilian Rehabilitation Branch of the Department of Labour. With the new Act, this approach is now endorsed and placed on a firm legislative foundation. Both immediate and long-range training needs should be kept in mind in planning training opportunities. What has been done so far can be part of a program to meet the continuing demands in the coming years. At the same time, staff training in the vocational rehabilitation program should mesh with developments taking place in the recruitment and training for all the social services. There is a body of skill and knowledge about helping people which has been built up over many years and which has been tested and refined in day to day practice. Methods for imparting this knowledge and skill have been devised. While no one should deny that there is, in fact must be,

room for change and improvement, this is a valuable store of experience on which training programs can draw. The vocational rehabilitation field not only benefits from this pool of experience but is contributing to it increasingly itself, particularly with respect to the techniques for helping people overcome economic and social dependency and in the imaginative use of resources.

Broad Range of Training Required

The training needs in the provincial vocational rehabilitation programs are quite diversified. Counsellors presently employed come to the job from a variety of backgrounds and experience. In many cases there are gaps in training which impede performance. There is usually, even on the part of trained staff, a need for knowledge and skills specific to the practice of vocational rehabilitation counselling and to the setting in which the counsellor works. Some difficulty is encountered, both at the levels of training and of practice, in distinguishing between the functions of a social worker in a rehabilitation setting and those of a rehabilitation counsellor.

Sometimes the two jobs seem to be interchangeable. Certainly they have much in common, particularly as to the skills required in working through a counselling relationship to attain certain goals with the disabled person. Training programs have, therefore, to meet a wide range of requirements in the areas of formal training, in-service training and job orientation, to say nothing of assuring adequate opportunity for on-going professional development at all times.

It would seem evident then, that one of the first tasks of those responsible for planning and carrying out staff training and development in a rehabilitation program or agency is to determine the role of the vocational rehabilitation counsellor and to decide the areas of skill, knowledge and competency which should be included in the training of counsellors.

Role of the Counsellor

Vocational rehabilitation is primarily concerned with the place of work or an occupation in the overall life of the individual. The general aim of vocational rehabilitation counselling has been described as follows: "To help the disabled person through the client-counsellor relationship

to make the best use of his personal and environmental resources in order to achieve the optimal occupational adjustment—this being an integral part of the individual's adjustment in all areas of his life.”*

The role of the vocational rehabilitation counsellor is to see that the services which help the disabled person to reach these goals are provided in an appropriate and orderly manner and that the client is helped to make use of them constructively. The performance of this function requires knowledge and skills, some which are similar to those required in related disciplines and some which are determined by the particular requirements of vocational rehabilitation.

The vocational rehabilitation counsellor is required to co-ordinate a wide range of services on behalf of his clients. He does not provide all of these himself, but he is the focal point, the continuing factor, in the rehabilitation process. He must establish and maintain liaison with sources of referral such as doctors, hospitals, community

organizations, departments of health and welfare and the education services. He has to assure that the disabled person is assessed socially, medically and vocationally, because the rehabilitation plan is largely determined by this information. He must be able to understand and use the information which he gains from his own knowledge of the client and from the knowledge gained through other sources.

The counsellor must also be skilled at seeking consultation and needs to understand the role of other disciplines in rehabilitation. He has to be familiar with labour market conditions and to understand the relationship between individual aptitudes and skills and job requirements. He should recognize the functional effects of disabilities and their vocational implications.

The counsellor works co-operatively with others, such as doctors, psychologists, social workers, vocational training experts and employment placement officers. Each of these contributes special experience and knowledge of the disabled client to the development of a suitable vocational rehabilitation plan. It is the counsellor's role to carry through this plan with the client and to keep closely in touch with each step in the process so that he can help with any difficulties or changes

* Critical Counselling Behavior in Rehabilitation Settings, by Marceline E. Jaques, 1959. An investigation supported by a grant from the Vocational Rehabilitation Administration of the U.S. Dept. of Health, Education and Welfare.



s they occur. There are inevitably a host of small details, and sometimes large problems, to be worked through before the rehabilitation goal can be reached. Many threads must be woven together in the process and in doing this the counsellor must always be flexible, realizing that he is working with a human person within a dynamic (changing) situation.

There can be no automatic pattern of rehabilitation which can be arbitrarily applied in all cases. As each individual is unique, so his rehabilitation plan and the way he responds to help are unique. The counsellor should follow through with his help and guidance until he is satisfied that the disabled individual has attained the best adjustment he can at that time in the prevailing personal and external circumstances.

Opportunity should exist for the disabled person to seek further help in the future should changes in these circumstances require. As the effectiveness of rehabilitation services is very much affected by the local community's resources, leadership, policies and attitudes, the counsellor's functions involve a recognition of the role the community plays in any rehabilitation effort.

Client-Counsellor Relationship

The essential part of the rehabilitation process is the relationship between the disabled individual and the counsellor, or rehabilitation worker. The skills and attitudes which are required by the counsellor to do his work effectively must be based on knowledge and on an understanding of human personality which should be an integral part of his training. Experience has shown that any effective attempt to help people must proceed from a concern for the uniqueness of each individual, an acceptance of the fact that the helping process can move no faster than the readiness of the person to make use of it (one cannot artificially set the pace of rehabilitation according to outside criteria of what constitutes "progress") and a true respect for the client's integrity and his own needs, wishes and interests. Perhaps the most important qualities of a good counsellor are those which are most difficult to impart through training. One of these is the ability to maintain a genuine feeling of concern for the client while not becoming personally caught up in his anxieties.

Another quality which is essential, but so hard to acquire, is that self-knowledge on the part of

the counsellor which helps him to understand and to refrain from judging his clients. The qualities which can never be taught in any training program, but which one hopes to find in good measure in all counsellors, are a large dose of common sense, a real liking for people and a sense of humour.

Skill in performing the role of counsellor can only come with experience. But training and knowledge are the raw material of competence and the equipment which the counsellor gradually learns to use as an expert should be sound and adequate. Opportunity must also be provided for new tools to be acquired and for basic equipment to be improved.

Counsellor Training Needs

The goals of vocational rehabilitation and the role of the counsellor to a large extent determine the areas of content which should be included in the training of counsellors. The most important area is that relating to counselling skills. Further, as vocational rehabilitation is concerned with "the world of work", there is a considerable body of knowledge to be mastered about occupations and methods of preparing disabled individuals for suitable employment in keeping with their abilities.

Also, this occupational aim of the rehabilitation process gives a very particular orientation to the way in which services and community resources are used by the counsellor on behalf of the client. The counsellor's responsibilities and functions in this aspect of his work require a wide knowledge of community resources as well as the ability to use them appropriately. The rehabilitation process itself calls for the integration of a variety of diverse factors. The skills of several professions are usually involved and it is important for counsellors to have an appreciation of the part played in rehabilitation by the different disciplines.

A consideration of some of the areas in which the vocational rehabilitation counsellor should be competent and knowledgeable will give an indication of his training needs:

An understanding of the philosophy and principles of rehabilitation;

Methods and techniques of the counselling relationship;

Human behaviour as related to personal, social and vocational adjustment;

Implications for the individual of handicapping conditions (the meaning of illness and disability);

Relationship of aptitudes, skills, interests, education and training to various occupational requirements;

Understanding of employment policies with respect to the handicapped;

In some settings, skill in employment placement;

Knowledge of the basic pattern of community organization and understanding of the services provided by public and private agencies;

Ability to understand and make appropriate use of services and information and to integrate these on behalf of the client;

Use of consultation with other professions and the ability to work co-operatively with others.

Expanding Training Opportunities

Present training opportunities could be expanded through developing courses at the undergraduate level, by widening the programs of the schools of social work (particularly the range of field-work placements in rehabilitation) and by the creation of university extension courses which could be taken while the staff members are still employed.

In-service training could then concentrate more on orientation to the particular program of the agency. The existing opportunities provided through special courses, institutes, workshops and conferences could also be enhanced.

There is the question, too, of providing incentives to staff to continue their training and development. Suggestions have been made in various quarters¹ that this might be done through the introduction of recognized certificates for levels of attainment, through the development of standards of general acceptance and by the use of salary differentials.

Every advantage should be taken by rehabilitation programs of studies on the use and training

of staff, particularly that of the Canadian Welfare Council's Commission on Education and Personnel at present underway.

Basic Questions

Some basic questions require further study to provide information to guide planning of staff training for the vocational rehabilitation field. Essentially, there are four basic questions:

What is the general aim of vocational rehabilitation?

What is the role of the rehabilitation counsellor in vocational rehabilitation?

What are the areas of knowledge and skill required for rehabilitation counselling?

How may this competence best be assured?

Related to these are many more specific questions requiring further exploration. Among those of first priority would probably be the following: Are there areas of knowledge and skill in vocational rehabilitation which can be considered "generic" to the whole field of the personal social services, particularly with the growing emphasis in these services on prevention, restoration and rehabilitation? Can some of these common elements be identified and included as part of the generic curriculum in schools of social work, both in theory and in field-work practice? Or, alternatively, is there a strong case for separate preparation of vocational rehabilitation counsellors?

Are there other equally important areas of vocational rehabilitation which can best be taught at the academic level but not necessarily in the school of social work? What are these other areas and how should they be taught?

What elements of the vocational rehabilitation job are best learned "on-the-job", through in-service training in the agency and through agency supervision? What are the best methods for staff training and development in this area?

What aspects of vocational rehabilitation most lend themselves to staff development through inter-agency and even inter-disciplinary workshops, seminars, short courses and conferences? What are the ways in which these training methods can be organized and how should their content be planned?

What are the different contributions in planning and carrying out an overall training program

¹ For example, the Needs and Resources Study of Community Resources in Metropolitan Toronto, Social Planning Council of Metropolitan Toronto, 1963, pp. 143-146.

be made by the employing agencies; by provincial rehabilitation authorities; by professional associations; by the universities; by other interested associations such as the Canadian Welfare Council and local welfare councils; by federal government departments and the National Co-ordinator's Office?

As a basis for planning, should there be a survey of training needs in each provincial program and nationally, to look at present requirements and to project these into the future? What changes or additions should be made to present training arrangements, both in vocational rehabilitation and in the social services generally with respect to rehabilitation?

Summary

The need for competent vocational rehabilitation counselling staff will grow and is acute now. Opportunity must be provided for basic training and on-going professional development of this staff. There is a body of skill and knowledge which is specific to vocational rehabilitation, in addition to those areas of competence required in other helping professions. A good look should be taken at how we can meet this need for recruitment and training most effectively.

However, such planning must not be done in isolation from the training needs in the social services generally, or vocational rehabilitation will only contribute to the proliferation of training programs for an increasing variety of closely related specialities—a form of “specialization” we can ill-afford. We should, as much as possible, therefore, know what training resources already exist, make use of these as they are and as they may be expanded, and develop those new opportunities which are found necessary to meet the particular training needs of vocational rehabilitation counsellors.

Our first and very large task is further to clarify and describe our present and future requirements for training and to ensure that we are well informed about existing and potential training resources.

While much of it has been on an *ad hoc* basis, some work has already been done in pulling together some of this information. What already is available in the way of training opportunities is by no means negligible and provides a good basis for further expansion. However, a clearer description of training requirements both present and future would contribute much to form a basis for rational planning.

WHAT OF THE EPILEPTIC?

By HARRIET HILL

Public Relations Officer

Montreal Council of Social Agencies

(Reprinted from *Canada's Mental Health*, bi-monthly publication of the Mental Health Division, Department of National Health and Welfare, Ottawa)

Canada has not yet begun to cope with the problems of the epileptic. Public opinion clothes the victim of this disease in a shroud of superstition, making it virtually impossible for him to lead the normal life to which he is entitled. Employers shy at employing epileptics, schools may object to accepting the child with seizures, families of epileptics too frequently regard the disease as something about which to be ashamed.

Perhaps this attitude stems from the ancient belief that people who suffer seizures are possessed. Today, the science of medicine has

shattered these misconceptions. But the myths linger on. They seem entrenched in the minds of even intelligent citizens, making it difficult to meet one of Canada's major health problems.

While the exact cause of epilepsy still defeats medical specialists, many facts about the disease have become known. Medical authorities now agree that the majority of epileptics are, in every other respect, normal human beings. Their intelligence scores are comparable to the population in general. Some are geniuses.

Epilepsy Widespread

Moreover, the extent of epilepsy in Canada is far greater than often realized. Applying U.S. Selective Service and Draft rates for the two World Wars, rates usually regarded as standard for most western countries, 0.5 per cent of Canadians have had seizures at one time or another. Other research suggests that 80 per cent of them can have their seizures completely controlled, or at least reduced.

Employers who refuse to give them jobs because they fear an effect on employee morale, or because they believe epileptics have more accidents, have been proven wrong by careful industrial studies. Workmen's Compensation studies in Canada and the United States indicate employees suffering from epilepsy can be "safe" workers, if properly assessed and given selected types of work.

Why then do these outmoded attitudes persist? A Montreal Council of Social Agencies Committee, with the neurologists of the Montreal Neurological Institute and the Department of Neuro-Psychiatry of Hotel Dieu Hospital, have been taking a long look at what can be done and its findings might prove a guide for other Canadian centres.

First, they staged a one day Conference* on the Rehabilitation of Seizure Patients with Dr. C. A. Roberts, Medical Director of Verdun Protestant Hospital, in the chair. At the outset, Dr. Francis McNaughton of the Montreal Neurological Institute had words of hope: "Each year new drugs are developed which may eventually lead to more effective control of attacks. With increasing understanding of their social needs and more adequate social services to meet them, it should be possible for three-quarters of our seizure patients to live useful, productive lives".

Fear is the Villain

It soon emerged that fear was the villain. And, unfortunately, the fear usually begins with the epileptic himself. He is afraid of being denied a normal life. This fear is contagious and spreads

into the community. How can it be stopped? The Conference agreed that an enlightened public was certainly one of the answers and any public education program must reach every segment of the population.

The Conference strongly advocated the establishment of a Co-ordinating Centre and Central Registry for Seizure Patients to serve both French and English-speaking communities. The Centre would spearhead a three-pronged education program directed to the patients, employers and the general public. The Centre would collect and exchange information between neurologists, general physicians, and industrial physicians. It would provide statistics and educational material for employing groups. The Conference concluded by establishing a Planning Committee to explore the formation of such a new Centre.

The Planning Committee has been hard at work. An *ad hoc* committee, with representation from Le Conseil des Oeuvres, has been formed to carry out some of the specific details. A Board has been named under the chairmanship of Rosaire Courtois, a prominent Montreal businessman. The new over-all organization is to be called "The Association for Epileptics—Association pour Epileptiques" and will involve both English and French communities. Its first duty will be to organize a Centre of Co-ordination for Epileptics with a permanent staff.

In the Committee's view there needs to be an assessment and grading of epileptics, as in the case of heart patients. Recommendations from physicians need to be specific, spelling out in detail just what the patient can and cannot undertake. Since epileptics are frequently inadequately educated, they find themselves ill-prepared for normal living. It is therefore important that wherever possible, epileptic children attend school. Ordinary school is best; only a minority really require special schools. The real problem is educating the educators.

Educating Industry

In industry, the Committee feels, more than management needs to be enlightened. Foremen, employees, trade unions, as well as the epileptic himself, must be involved. The industrial nurse should assume responsibility for educating supervisory personnel. She can do a great deal to

* Formally referred to as an "Institute", the word "Conference" is used in this article to avoid confusion with the Montreal Neurological Institute. The Proceedings of this Institute on Rehabilitation of Seizure Patients, 52pp., \$1.25, is available from the Council, 1020 Atwater Ave., Montreal 6, Que.

prevent possible prejudice by helping supervisors really understand the employee's problem and by reassuring him that the nurse, or trained "first aiders", can easily manage a patient's seizure should it occur.

Then, too, there are epileptics who cannot be employed in regular industry and require special arrangements such as sheltered workshops. "Half-way" houses are needed also to enable patients discharged from an institution to readjust to

community pressures before being launched into competitive employment. Without such houses, the Committee believes, the epileptic faces stress which makes the transition more difficult.

We still have a long way to go—adequate funds as always, are a major problem—but at least the route is being paved which can lead to a new life for the epileptic, one which will entitle him to live and play just as normally as his neighbors.

International Society for Rehabilitation of the Disabled

WORLD CONGRESS 1963

THE DISABLED CHILD AND HIS REHABILITATION

By RAY AULD, *Executive Director*

Ontario Society for Crippled Children

To be in Copenhagen in June, 1963 was to be part of a huge international fraternity of rehabilitation workers meeting for the first time in the congenial and invigorating atmosphere of Denmark's beautiful capital. It was an ideal setting in which to bring together more than 1,700 persons representing 66 countries in a tangible demonstration of the world-wide concern for our millions of physically handicapped people. An ideal setting because Denmark takes second place to no other nation in its hospitality to visitors or in its devotion to the welfare and well-being of its own citizens.

The program of the Ninth World Congress of the International Society for Rehabilitation of the Disabled was as full and as varied a program as the host organization—the Society and Home for Cripples of Denmark—could devise. Theme of the 1963 Congress was *Disability: Prevention and Rehabilitation*. Within this all-embracing theme, papers were presented on a wide variety of disability-producing conditions: arthritis, cerebral palsy, leprosy, paraplegia, hemophilia, epilepsy,

congenital defects, and others. Special commissions and committees reported on and discussed topics of concern within the branches of rehabilitation—therapeutic care, special education, speech and hearing, prosthetics, vocational assessment and training, and research. It was inevitable and encouraging that the perennial problems of co-ordination of services, and communications, should have received a fair share of attention and discussion.

The breadth of the Congress program imposed a very strict limitation on the participation of all delegates. There were simply too many events going on concurrently for one person to take them all in and arbitrary choices had to be made, usually with great reluctance. Because of a primary concern with crippled children, my choice had to be in favour of those parts of the program dealing with children. Even in this restricted area, however, it was possible to detect two main currents of opinion which seemed to permeate the entire Congress and which were confirmed in private conversation with delegates.

Glowing Enthusiasm

The first of these currents was the glowing enthusiasm shown by delegates from countries which had recently launched their first rehabilitation programs. The desire of these countries to take a full part and place in the world-wide rehabilitation movement and to exploit their initial successes was a source of tremendous encouragement and pride to all delegates. It was impossible not to be caught up in the exhilaration brought to the Congress by these new converts to the cause of rehabilitation.

The second current was the more sobering revelation that many countries which have had rehabilitation programs for a number of years and have come to regard their programs with satisfaction are beginning to have doubts, and to examine critically the effectiveness and efficiency of long-standing programs. The mood of the Congress was that this disturbing but necessary self-analysis might still hold promise of advancement if voluntary agencies, governments, and rehabilitation workers themselves are willing to move with the times and to re-vamp and adapt present techniques to meet the rapidly changing needs of rapidly increasing populations of handicapped persons.

Cerebral palsied children form a large part of the caseload of organizations serving crippled children, and the meetings of the World Commission on Cerebral Palsy were a "must" for delegates from these organizations. Papers presented on June 24 under the chairmanship of Professor Guy Tardieu, of France, dealt with the post-natally acquired cerebral palsies in terms of the numbers of such cases, and their diagnosis and treatment. Surgical treatment of upper extremities and assessment of hand function in the cerebral palsied child were also discussed by specialists from Poland and Great Britain.

Variety of Papers

Dr. Keith S. Armstrong, of Canada, chaired a joint meeting of the Committee on Special Education and the World Commission on Cerebral Palsy on June 25. Dr. Sam Rabinovitch, of Montreal, presented a paper on "Persistent Theoretical Issues Related to the Education of Cerebral Palsied Children", and other speakers covered

other aspects of the psychology and special education of these children. On the following day, the World Commission met with the Commission on Vocational Rehabilitation and among the excellent papers presented, the one by Dr. Margaret Jones, of Los Angeles, reporting her survey on vocational rehabilitation of cerebral palsied young adults, was of particular interest to those who face the often discouraging task of finding suitable placement for this group of handicapped adults. Dr. Jones reported that 20-30 per cent of all cerebral palsied adults are capable of competitive employment if given special training and placement. Important early factors in successful placement, mentioned by Dr. Jones, were: early training in the family toward independence and the development of realistic goals; possession of at least borderline intelligence, manual dexterity enough to be independent in self-help, ability to travel alone, and good personality and work habits. Facilities needed in the community were: services for evaluation and training beginning at age 10-12, counselling for family and individual, sheltered and vocational workshops, selective placement, and community education of employers.

The tragic incidence of thalidomide-induced deformity in children lent a sense of urgency to that part of the Congress which dealt with the rehabilitation of children with congenital defects. This session, under the chairmanship of Professor K. Lindemann, of Germany, featured papers by a number of experts including Dr. Gustave Gingras, Mr. Bernard Hebert, and Dr. Philippe Moreault, of Canada.



As a representative of a voluntary agency, and also as a judge of the Reader's Digest Awards presented at Copenhagen, it was interesting to note how frequently the submissions for the distinguished awards indicated that new rehabilitation programs had been started by individuals or small groups, often in the face of apathy on the part of the general public and even of governments. Rehabilitation, it is clear, still requires hard selling, and the selling often falls to the voluntary agency before the need for services is understood or appreciated sufficiently by the public and their elected representatives.

Danish Rehabilitation Service

In mentioning the roles of voluntary agencies and governments, it was of particular interest to study the compromise worked out by the resourceful Danes. There, a neat balance has been established between social medicine and voluntary effort by virtue of the Danish Government's provision of full and comprehensive rehabilitation services for all citizens, not through official branches of government, but through private agencies. Although they are in effect agents of the Government, the private agencies retain a great deal of freedom to change, modify or expand exist-

ing services and to experiment in untried areas. The quality of service which results from this happy blending was readily apparent to those delegates who took the many opportunities provided for tours of Danish rehabilitation facilities.

Canada is playing an increasingly larger part in the work of the International Society for Rehabilitation of the Disabled, and the benefits to Canada of attendance at Congresses such as that held in Copenhagen in June will increase in direct proportion to the number of Canadian specialists and workers in rehabilitation who participate. For the past three years, Canada has provided leadership at the highest level. At the Congress in June, Mr. Hall H. Popham, of Ottawa, president of the International Society since 1960, was succeeded by Dr. C. W. de Ruijter, of the Netherlands.

During the next three years until the Tenth World Congress in Munich in 1966, many delegates to the 1963 Congress will be studying and restudying the questions raised in Copenhagen and applying some of the ideas proposed to their own rehabilitation programs. By 1966 new problems will have appeared, but with good planning, good will and good fortune, perhaps some of the most troublesome problems of 1963 will have been answered.

"THE BOAT TO DO THE JOB"

By GERALDINE CHAFE,

Rehabilitation Counsellor,

Department of Health, Newfoundland

"Anyone on board the *Christmas Seal* is going to see some hard things", Skipper Troake warned me as I went aboard for the first time. That was back in 1955, when the Department of Health was organizing its rehabilitation program, and the Newfoundland Tuberculosis Association offered the facilities of the Motor Vessel *Christmas Seal* for contacting handicapped persons along the coast.

I found it difficult to understand the Captain's warning, as I was launched into the excitement of work on the floating X-ray clinic. I fancied myself

a good sailor, and was soon and often called upon to prove my boast, as the 104-foot craft, once a U.S. Air Force rescue boat, rocked stem to stern like a see-saw. And this was not on really stormy days, for at such times the skipper prudently seeks shelter—but in clear, sunny weather when the sea is having a little fun with those who mar her surface. Captain Troake is a bit skeptical of the sea-faring abilities of city-dwellers, especially females, and for the first few days he was sure that I would have to go below as the waves climbed higher. But I never did, perhaps because

I was too engrossed in his heartfelt renditions of *Whispering Hope* and *Hard, Hard Times*, together with tales about Mother Carey's chickens and sailors' superstitions.

Expected and Welcomed

The *Christmas Seal* is always expected, and welcomed, wherever she goes, for announcements are made on the radio stations beforehand. As the boat comes in to the wharf, her speed is cut to slow ahead by engineer Benny Barbour, and the loudspeakers send lively music across the water to echo from the hills. People stop work in the gardens, in their homes, and at the wharves. Groups gather at the wharf where the boat will tie up. They watch as she approaches, everyone certain of her identity and purpose. Even without seeing the name black-painted on her bow, there can be no mistaking the shapely hull of the *Christmas Seal*, dazzling white in the sunlight. Residents of 1,300 communities in Newfoundland have seen the boat in their harbours twice, many of them three times. Of course, the greatest mark of identification is the white flag with the red double-barred cross, world-wide symbol of the fight against tuberculosis.

As the Captain skilfully edges the boat in to the side of the wharf, there is always someone on shore waiting to catch the ropes tossed in precisely by the mate Ches Pelley and his assistant, Ches Bishop. As soon as the gangplank is in place, people start coming aboard for their chest X-rays. At the same time, the first announcement is being made through the loudspeakers.

One of the first times I used a microphone was on board the *Christmas Seal*, but the importance of what I had to say diminished any mike-fright I was inclined to feel. First, the people had to be told about the X-ray survey, and how important it is that everybody, including older people, have their chests X-rayed. Then I made my own announcement, asking handicapped people to come on board to discuss their problems and also the Department of Health services that may assist in their rehabilitation.

B.C.G. vaccination is also done on the boat when it is working in an area where the Department of Health is carrying out its B.C.G. program. Positive reactors to the skin test are X-rayed aboard the *Christmas Seal*, and the boat also offers transportation for the B.C.G. nurse whenever needed.



The M.V. *Christmas-Seal* making one of her calls.



Patients visit the craft at outlying settlements.

Additional Service

Another recent service made available on the *Christmas Seal* is a diabetes case-finding survey. During past summers, a representative of the Diabetic Association has travelled on the boat to do this work. A brief, simple test is given, and the results indicate whether there is any likelihood that the person has diabetes.

With all this work going on, the *Christmas Seal* is a busy spot. People coming for a chest X-ray receive a registration card in a room next to the wheelhouse. Then they move aft on the port side to the X-ray room, where technician Bert Stokes X-rays each one with his modern equipment. All day long, Bert can be heard "Take a deep breath . . . hold it . . . thank you, you may go now." Sometimes there is a little delay, while one of the ladies removes a favourite brooch from her collar, or a small child has to be knelt on a stool to reach the X-ray machine,

but Bert often X-rays more than a person a minute.

As often as possible, a doctor and a nurse travel on the boat. Those who are called back for a second X-ray, are seen by the doctor who reads their X-rays in the boat's lounge. Most of the time, he can tell them they have no trouble at all in their lungs, but sometimes he must tell them that they need treatment. When a case of active TB is found, arrangements are made immediately for admission to a sanatorium.

The nurse's most important duty is to go ashore and visit all known ex-tuberculous patients, to make sure that they and their families are X-rayed.

The diabetes technician uses the facilities of a small room off the X-ray room, and as rehabilitation officer I have interviewed handicapped persons in the wheelhouse, on deck, and on shore—whichever place was convenient at the time. During the past few years, most of the work of the rehabilitation survey has been done by Mr.

William Lane, a Memorial University medical student who works with the Department of Health during vacation.

Length of Visits

The length of time the *Christmas Seal* remains in each place depends on the response to the X-ray survey. When the people come quickly, the work is soon finished. When the response is not considered good, special announcements are made to encourage the tardy ones to take advantage of the service. This usually brings results, although there are always a few who let fear or indifference keep them away. The fact that the response falls short of 100 per cent shows that there is a great need to continue the health education program. Whenever practical, educational films are shown. Sometimes this is done by setting up a screen on the deck or the wharf, and running the projector with power from the boat's generator. I once had the unique experience of watching a movie on a wharf, with a lavish Labrador sunset as backdrop.

While the boat is working, the loudspeakers continue to broadcast music, spotted with messages about the importance of good health practices, education and rehabilitation.

Sometimes, when the tide is low, the boat cannot tie up at a wharf, as she draws eight feet of water. As we anchor offshore, the people in the settlement head for their small boats. The fishermen give willingly of their time, bringing neighbours out to be X-rayed. The continuous coming and going of punts, dories, and trap skiffs, loaded with men, women, and children is an inspiring demonstration of community effort. When some of the men are out on the fishing grounds, the women row the boats themselves. And more than once, a man in his seventies has rowed out to the *Christmas Seal* to have his X-ray. These older men are the special proteges of the skipper, with whom they swap many a salty yarn, and sometimes even break into a spirited jig on the green-painted deck.

Other welcome visitors to the *Christmas Seal* are the local doctor, welfare officer, Seal Sale chairman, clergyman, and teacher.

When the last X-ray is taken, an announcement is made to thank the people and to remind them that their Christmas Seal dollars have helped to

pay for the survey. Then the anchor is pulled up, the whistle sounded, the last visitor scrambles ashore, and the boat heads for the next settlement. Most of the time, this means that another routine program is to be carried out, but sometimes there is something special going on.

Teachers' Institutes

Each year, the Newfoundland Tuberculosis Association organizes several teachers' institutes, with the co-operation of the Departments of Health and Education. Usually, at least one of them is held in a central community in an area where the *Christmas Seal* is working. On the way, the boat picks up some of the teachers going to the meeting, while others come by chartered cars and small boats. Also attending the institutes are chairmen of town councils, doctors, nurses, magistrates, welfare officers, and representatives of service clubs, Jubilee Guilds and other organizations. The institutes consist of talks and discussions on sanitation, nutrition, tuberculosis, and rehabilitation—with emphasis on the teacher's contribution to community health and welfare.

In addition to saving lives by prevention and detection of TB, the *Christmas Seal* has on several occasions gone out of her way to rush a critically ill person to hospital.

I was not on board very long, before I discovered what the skipper meant when he said I would see some hard things. He was thinking of the family of six or seven children whose mother had to leave them while she received treatment in a sanatorium; he was thinking of the little child deafened or disabled by TB meningitis because a tuberculous parent or grandparent refused treatment and infected the child. As a rehabilitation worker, I observed many other tragic situations:—men who became disabled early in life and never had an opportunity to become self-supporting; men who went to school until they reached Grade Four or Five, then started fishing or lumbering, and later suffered an accident or illness that prevents them from doing the only kind of work they know; and most disturbing of all—handicapped children whose parents will not allow them out of sight to obtain the medical treatment, education, or vocational training that will make them independent, well-adjusted persons.

Brighter Side

Fortunately, there is a brighter side to all these pictures. More people are realizing the value of X-rays, and TB discovered early can be treated more effectively than ever before. More people are beginning to understand, too, that most handicapped persons can earn a living if they have the right attitudes and are given the necessary opportunities.

Pleasant impressions last the longest, and I shall always have memories of the politeness, good humour, and sincerity of our people around the coast. Even without photographs, I remember vividly the yellow-painted church at Conne River, looking at a distance, like an old castle among the trees; the purple hills of Parsons' Harbour slashed with lighter vertical lines, as if an artist had just finished a bold sketch; horses galloping over the slopes of Fishing Ships Har-

bour in Labrador, to the tune of Colonel Bogey's March played on the boat's loudspeakers; the tiny, fairy-tale church hidden in a grove at Cartwright; the translucent green of chunky icebergs along the coast—and best of all, the knowledge that I have had the privilege of working on a boat with a crew and staff devoted to improvement of the health and welfare of our people, a boat that can set down in her log: 1,300 communities visited and revisited, along 6,000 miles of jagged coastline; over 300,000 examinations for tuberculosis; nearly 9,000 persons tested for diabetes; more than 600 handicapped persons contacted, with the result that many have been started on the road to successful rehabilitation. With this record in mind, I can only say with Captain Troake of the *Christmas Seal*, "I'll guarantee you, she's the boat to do the job, all right."

MEDIC-ALERT FOUNDATION

(From the July-August 1962 Journal of Rehabilitation, official publication of the National Rehabilitation Association, Washington, D.C., U.S.A.)

Many persons who live in fear that their hidden medical problems will not be recognized in case of accident or other emergency are now offered protection and peace of mind through the Medic-Alert Foundation International.

Medic-Alert is a charitable, non-profit organization that provides indestructible stainless steel or silver bracelets, emblems, and medallions with universally-recognized insignia and engraved medical warnings. The emblems were developed to provide protection and ensure immediate and proper attention for people with hidden medical problems and allergies.

The emblems have a medical insignia and the words "Medic-Alert" engraved in red on one side. On the reverse side is an engraved warning that alerts physicians, rescue squads, or passersby to the medical problem or problems of the wearer who may be in a state of shock, delirium, or unconsciousness as the result of an accident, seizure, or other emergency.

Headquarters of the foundation maintains a central file of the medical records of its emblem-



wearers under serial numbers corresponding to those engraved on the emblems. The information in these files is available to physicians and other authorized personnel on a 24-hour collect-call basis.

Medic-Alert was established by a Turlock, California, physician, Dr. Marion C. Collins. Prompted by the near death of his daughter, because no one knew she was allergic to antitetanus serum, Dr. Collins devised a silver bracelet for her with the words "Allergic to Tetanus Anti-Toxin" engraved on the back.

He then realized that such an indestructible bracelet or necklace with its vital message would help avoid fatal delays in summoning aid for people suffering from diabetes, epilepsy, or hemophilia and for others with drug allergies, rare blood types, and countless other hidden illnesses.

There followed months of planning and consultations with physicians, nurses, law enforcement agencies, and national leaders; in 1956 the Medic-Alert Foundation was established.

The Medic-Alert emblems are attractive and durable and are to be worn at all times—while swimming, bathing, and water-skiing, and even when wearing formal evening gowns—because emergencies can occur at any time. The Foundation has found that plastic locket-type and wrist-case holders are unsatisfactory because water, dust, perspiration, and other factors tend to render the enclosed message illegible in an emergency.

It has also been found that expansion wrist bands fly off in case of accidents; police have found wrist watches as far as 75 feet from the site of accident impact. When a person with an expansion band medical emblem needs its protection most, it could thus literally have flown out of sight. Medic-Alert bracelets are made with strong chains and sister hooks, as advocated by peace officers' associations.

Samples of inscriptions on Medic-Alert emblems are: Allergic to Horse Serum; Allergic to Penicillin; Diabetes; Epilepsy; Glaucoma; Hemophilia; I am Taking Anti-Coagulants; Multiple Sclerosis; Myasthenia Gravis; Neck Breather; Allergic to Bee Stings; Wearing Contact Lenses; Commercial Deep-Sea Diver; and Skin Diver. Other possibilities are the inscription of blood type and RH factor.

The Medic-Alert Foundation, which is endorsed by many medical and civic associations, conducts a year-round educational program directed toward physicians, hospitals, nurses, law-enforcement agencies, fire departments, rescue squads, and the general public.

Purpose of the educational program is to familiarize everyone with the Medic-Alert emblem and its meaning and to look for it immediately on accident victims. The program also attempts to inform all persons with hidden medical problems

of the benefits and protection afforded them by wearing the insignia.

Medic-Alert is supported by the one-time only membership fee, which includes the cost of the bracelet or medallion. The services and protection of the central file are included in the membership. These files include not only the member's medical record, but also his address, physician's name and address, and identification of the nearest relative or friend to be called in time of emergency. A member is issued his choice of Medic-Alert emblem with medical problem and serial number engraved on the back; he also receives a small membership card, which gives further medical information.

Originating in the United States, the Foundation is now recognized internationally. The Canadian Medic-Alert Foundation was established in 1961 with its own Board of Directors and now has over 5,000 persons wearing the Medic-Alert medallion in Canada.

As Dr. Collins has stated, "There is little point in . . . developing miraculous drugs if they are not administered properly, or in time, as is often the case because the attending physician or policeman has no way of knowing about the victim's medical problem." Thousands of cases are recorded each year of accident victims reacting violently, sometimes fatally, to certain drugs. Policemen have mistakenly taken diabetics to jail as drunks instead of to hospitals.

These tragic mistakes are no one's fault. There is just no way of knowing about the person's problem while he is unconscious or in a coma. This is why Medic-Alert was established.

Anyone wishing further information should write to Canadian Medic-Alert Foundation, 17 St. George St., Toronto, Ontario.



EXPANSION IN SHELTERED EMPLOYMENT

With the expansion of Canada's rehabilitation program there is evidence of an increasing interest and development of sheltered employment facilities throughout the country. An example is the recent expansion of the Edmonton Sheltered Workshop, which has been providing service to the disabled of the community since 1955. In December, a "Goodwill" workshop and store was opened. This type of workshop receives discarded household articles and clothing, renovates and repairs them and sells them in the shop. This provides many opportunities for training disabled persons in a variety of skills.

Ontario Division CNIB

The Ontario Division of the Canadian National Institute for the Blind has also instituted several new projects during the past year. A large adjustment-training centre at Bakerwood in Toronto provided a three months training program for 14 newly blind persons, of whom eight were returned to employment and others were referred for further training with the catering department.

Another new project was the re-arrangement of several Bakerwood shops to develop a more productive flow of work and to establish a new phase of employment—the completion of sub-contracts from outside industry. This provided facilities for full-time employment of 50 people with sufficient facilities for future expansion. A sub-contract supervisor was appointed to obtain jobs, not only for this shop, but for other CNIB shops throughout the province.

A film-processing room was also built for the training of blind X-ray technicians. Over the past 15 years, X-ray film processing has proved a satisfactory career for several blind persons, but training had to be arranged through hospital facilities. While 10 blind people in Ontario are now employed in this work, these training facilities will open the field to many more.

Through the facilities of the catering department, 43 persons were given on-the-job training for employment in various CNIB locations. Before the year ended, 17 were placed in catering positions. This brings to 246 the number of

blind persons employed in this department. Industrial employment also remained high. Through the efforts of the four CNIB placement officers, 487 blind industrial workers are employed.

Three blind university students successfully completed studies in law, music and social work and are continuing their careers in their chosen fields. There are now 18 blind students in the universities of Ontario.

Regina Sheltered Workshop Moves

The sheltered workshop of the Saskatchewan Council for Crippled Children and Adults has moved to a temporary location at 1740 Lorne Street, Regina, while awaiting the construction of its new building.

Handicapped Workers Make Christmas Seals

The Calgary Rehabilitation Centre, which began manufacturing decorated seals for Christmas five years ago as a small sideline, has developed it into a major industry.

Used Christmas cards are collected, sorted, and the chosen cards are sent out to five disabled persons, confined to their homes, for cutting. They are returned to the centre where other handicapped persons spray on the glue and package them.

The seals sell for 15 cents per package of 10 seals. High standards of workmanship must be maintained by all workers so that the seals sell on their own merit.

Ottawa Neighbourhood Services

The annual report of the Ottawa Neighbourhood Services indicates an expansion of activities also. This is a salvage type of operation and seeks to provide employment, training, work evaluation and adjustment services to handicapped and needy persons; to provide limited emergency relief services to the needy in conjunction with recognized welfare groups, and to provide clean reconditioned clothing, furniture and other house-

hold articles to persons of limited means through its retail stores. This is a self-sustaining operation entirely dependent on the income derived from the sale of the reconditioned materials processed by the handicapped.

During the year employment was given to 118 workers on a full or part-time basis. Average rate of pay was \$1.10 per hour. These 118 persons paid \$5,768.75 in income tax.

The report states, "For some this was their first job. For others it meant employment after years of idleness. For the older worker it meant part-time employment to supplement his pension.

"Utilization of the skills of handicapped workers in productive employment is sound and necessary, both for the contribution these workers can make to our national productivity and for the sense of independence and well-being they can derive from doing a good job.

"In our workshops handicapped people with virtually all types of disability are successfully performing jobs of almost every conceivable occupation because their abilities have been found to be adequate for job performance and the disabilities not to be a restricting factor."

Sault Ste. Marie Workshop

Operation Reclaim (Algoma) Inc., is also a salvage type of sheltered workshop and was formed in Sault Ste. Marie in June, 1962, beginning operations in September of the same year. It is already proving its value in the community. The staff at present consists of eight persons, three of whom have never worked before but who are proving to be most valuable employees.

A branch of Marina Creations has also been organized in the Sault Ste. Marie area with about 12 disabled persons participating and more expected to join.

NEW DEVELOPMENTS AT MANITOBA REHABILITATION HOSPITAL

A number of developments in the Manitoba Rehabilitation Hospital's prosthetic and orthotic program have been announced in recent months. These include the appointment of a medical director of the Prosthetic and Orthotic Research and Development Unit, the establishment of a prosthetics workshop for physical and occupational therapists and the opening of medical clinics at the Hospital and at the Children's Hospital in Winnipeg.

Medical Director

The new medical director is orthopedic surgeon Dr. F. R. Tucker, an associate professor in the department of surgery and head of the sub-department of orthopedic surgery at the University of Manitoba. Dr. Tucker will have charge of the clinical aspects of the unit's work.

Prosthetics Workshop

The prosthetics workshop program at present comprises courses in the fitting and aligning of

prosthetic appliances for the lower limbs. Eventually it will include a demonstration of how they are made. The weekly one-hour sessions are in charge of Dr. Tucker and James Foort, technical director of the hospital's bio-mechanics laboratory. Mr. Foort is a research engineer with extensive experience in prosthetics and orthotics at Sunnybrook Hospital, Toronto, and at the University of California at Berkeley and San Francisco. He and Dr. Tucker will be working closely together in arranging a three-pronged program of treatment, education and research.

This unit of the Rehabilitation Hospital has been selected by the federal and provincial governments to act as a treatment, research and training centre for Western Canada. It is financed by a National Health Grant and is administered by the Sanatorium Board of Manitoba with the full support of the Provincial Minister of Health.

One of the unit's main and early objectives is to provide medical and prosthetic care for the limbless victims. A second aim is to raise the

standards of prosthetic (artificial limbs) and orthotic (braces) care in Manitoba and in Western Canada.

Medical Clinics Established

In the furthering of this aim two medical clinics have been opened, one at the Manitoba Rehabilitation Hospital and one at the Children's Hospital in Winnipeg.

At the Rehabilitation Hospital, clinics are now held each Monday for amputees who need to be fitted with, and trained in the use of, artificial

limbs. This service will soon be extended to include disabled persons who require braces and other mechanical aids.

Monthly clinics will be held at the Children's hospital to provide similar service for children (16 years of age and under).

At both clinics persons are referred—either as in-patients or out-patients—at the request of their own private physicians, who continue to provide any accompanying treatment. Doctors may refer their patients for full service or for consultation only.

THE HANDICAPPED - WHEN CAN HE WORK?

(Reprinted from the Journal of the American Medical Association, Vol. 186, No. 1, October 5, 1963 by kind permission of the American Medical Association)

When is the handicapped individual ready for employment? According to Dr. Thomas Gucker, III, of Los Angeles, who spoke before the 23rd Annual Congress on Occupational Health at San Francisco, the physician should determine this by answering "pertinent" questions regarding physical, psychological, and occupational readiness although his "primary obligation is to determine whether the individual has received maximum benefits of medical care."

He included the following as specific questions regarding physical readiness: Is he at maximal physical capacity? Can he travel to and from the job? Can he work a full day and/or week? Can he meet the physical demands of the kind of work sought? Does he understand the nature of, and limitations imposed by, the disability? Is he aware of activities and situations that would tend to aggravate his disability or impair his general health? Does he know danger signs like fatigue as warnings that rest or treatment may be necessary? Is he aware of the need for further treatment or periodic examination?

Psychological readiness may be determined by answering the following questions, says Gucker. Does he and his family accept these limitations? Does he and his family recognize his capabilities? Is he sincerely motivated toward employment? Can he adjust to the strains and pressure of the work environment? Does he react well to other people? Is his behaviour appropriate to the job

demand? Are his personality traits in keeping with the job tasks? Are there personal or social problems that might affect his performance on the job?

"Occupational readiness is not the primary responsibility of the physician and expert advice must be sought from the counselors . . . the past work history is important as a guide toward future trends. We must ask: What has he done? How long and when did he do it? Why did he leave the job or training?"

If the client is ready for employment the physician should turn the responsibility over to the counsellor and placement worker, says Gucker. "Certain observations, however, should be made which concern everybody dealing with the handicapped and especially the employer."

First, there may need to be orientation to personnel policies and procedures, company rules and regulations, and the physical layout of the place of employment. Second, adaptation may be required of client performance of job duties, of methods or machinery involved in the job, and of physical facilities or arrangements.

Third, problems may be lessened or avoided by co-operation with the supervisor and co-workers, by continuance of medical or other treatment, by understanding expected timing of pay rises and promotions, and by avoidance of quitting the job before consulting the counsellor.

People and Events

Nurses Study Rehabilitation Nursing

A course in rehabilitation nursing for graduate nurses was provided at the Manitoba Rehabilitation Hospital from October 8 to December 19. This course covered every aspect of medical rehabilitation of the physically handicapped, the chronically sick and convalescent persons. It included observation of the specialized services offered by physiotherapists, remedial occupational therapists, speech therapists and the work of the Bio-mechanics Laboratory and the Prosthetic and Orthotic Research and Development Unit. Attention was also directed to the services of the electromyography department, the social service and dietary departments and the research laboratories.

The specialist speakers included the staff of the hospital, consultant staff and the personnel of the University of Manitoba's School of Medical Rehabilitation.

New Centre opened in Winnipeg

Manitoba's Health Minister, George Johnson, officially opened Winnipeg's \$450,000 Kinsmen Centre for the Handicapped. The new building has special facilities for training pre-school children suffering cerebral palsy or deafness. The program for pre-school deaf children, which started in September, is the first service of its kind offered in the province.

The Society for Crippled Children and Adults of Manitoba has moved its offices into this new building, as have the Manitoba Division of the Canadian Arthritis and Rheumatism Society and the Central Western Division of the Canadian Paraplegic Society. The address is 825 Sherbrook St., Winnipeg 2.

A plaque in memory of Stephen C. Sparling, Executive Director of the Society of Crippled Children and Adults of Manitoba from 1951 until his death in 1961, was unveiled on November 29. This plaque will be placed in the Pre-school Centre.

Facilities for Handicapped Students Under Study at University of Manitoba

One of the problems encountered in fitting the disabled person into every-day life is that of acquiring a higher education.

At present among the disabled attending the University of Manitoba is a wheel-chair student in fourth year arts, another in fourth year science, several blind persons, and some otherwise handicapped.

Cecil Blankstein, well-known Winnipeg architect, and "Tony" Mann, Director of the Manitoba Paraplegic Association, representing the Manitoba Committee for Accommodation for the Physically Handicapped, met recently with Jack Hoogstraten, Vice-President of the University of Manitoba, (in charge of development) to consider physical problems of disabled students.

As a result of these discussions, arrangements have been made for a survey of present and future facilities. The committee expects to make suggestions as to what modifications might be made at the University to make the school year a little less difficult for physically handicapped scholars.

The survey is being accomplished with the assistance of Allan Simpson, a recent commerce graduate, and George Dyck, a fourth year science student. These two men are confined to wheel chairs and are fully acquainted with the hazards involved in pursuing an education at a building designed for the physically fit. They have been aided by the Griffons Club of Winnipeg which provided mobile and physical assistance during the survey.

Recommendations to Mr. Hoogstraten will be made for changes in such areas as entrances, where doors might be widened or ramps built in place of stairs; washrooms with wider doors and hand rails; perhaps special keys to service elevators.

Mr. Hoogstraten has agreed to make available to Mr. Blankstein plans for future buildings. It is hoped that with his guidance previous oversights can be corrected.

Contact has been made with other colleges for the purposes of continuing the survey.

(Manitoba Department of Health News December 1963.)

International Society's Secretary-General Honoured

Donald V. Wilson, Secretary-General of the International Society for Rehabilitation of the Disabled has received the honoured award of the Commander of the Royal Order of Phoenix bestowed by His Majesty, the King of the Hellenes. This Order, awarded in December, is given to show appreciation of services rendered to the cause of friendship and understanding between the United States and Greece.

Award Winners

C.A. Pippy Awards—A blind woman and a man crippled by polio were 1963 winners of the Newfoundland C.A. Pippy awards.

Elizabeth Madden was born in Petty Harbor and has been blind since an early age. She had never had the opportunity of a formal education. At the age of 22 she came to the attention of the CNIB and received instruction in Braille and handicrafts. She recently completed a correspondence course in English from the Hadley School for the Blind.

Miss Madden was the first blind girl in the Girl Guide movement in Newfoundland. She has helped organize bowling for the blind in the province, has taken a St. John Ambulance Course in home nursing and helped organize a class for blind persons in this subject. She is an active member of the Canadian Council of the Blind in the province. Miss Madden operates a CNIB unit at the Unemployment Insurance Building, Port Pepperel.

Clarence MacLean of North West River, Labrador, was a worker with the Grenfell Mission when he was struck by polio at the age of 31 leaving him with paralysis of both legs. It was two years before he was able to walk with the aid of two canes. Following his discharge from hospital he took a training course in electricity at the Vocational Institute in St. John's and returned to his job at the Grenfell Mission.

Mr. MacLean has helped set up power houses at North West River and Nain. He wired most of the new construction in this area and has become a "trouble-shooter" for electrical problems. He has acted as tractor driver, mechanic, electrician and sometimes radio-telephone operator in carrying out mission business.

Clarence MacLean has become known and admired for his perseverance, for his readiness to help others and for his activities in local affairs.

Arthur D. Stairs "Man of the Year" Award—Two outstanding Canadians shared the Arthur D. Stairs "Man of the Year" award presented annually by the Canadian Paraplegic Association Maritime Division. The award is presented each year to an outstanding paraplegic who has made the best adjustment to a new way of life, undertaken and conquered new activities, and successfully worked out a new pattern of independence under disability. This is true of both winners. William J. Atton, a Halifax barrister, is carrying on in his profession successfully and Victor Bennett, forced to give up his former life as a seaman, studied and prepared himself for a new way of life and is now information officer at the Provincial Trade School.

Jewish Vocational Service Receives Award

The Jewish Vocational Service of Toronto has been given an "honourable mention" citation in the William J. Shroder Memorial Award Competition. The award is in recognition of its efforts to retrain workers displaced from jobs by technology and automation. To help meet the needs of such persons, the Jewish Vocational Service began a training program in building maintenance in 1962 and, to date, has prepared over 200 unemployed men for jobs as building caretakers. The Toronto Jewish Vocational Service is the first Canadian agency to be cited since the awards were begun in 1952.

Toronto Rehabilitation Centre Opened

Hundreds of persons overflowed into the halls, foyer and gymnasium of the new Toronto Rehabilitation Centre on October 23 to watch Premier John Robarts open this addition to Metropolitan Toronto's Rehabilitation City in Leaside. The centre is close to the Ontario Society for Crippled Children, the Canadian National Institute for the Blind and Sunnybrook Hospital. Mr. Robarts praised the energy and imagination behind the building of the centre. The new rehabilitation centre has a therapeutic swimming pool with a hydraulic lift for patients unable to walk, a multi-purpose gymnasium, and well-equipped treatment rooms.

Council on Social Work Education, Toronto

Toronto was host to the 12th Annual Meeting of the Council on Social Work Education, from January 29 to February 1, 1964, held at the Royal York Hotel. The Council is the planning and standard-setting body dealing with curriculum for post-graduate schools of social work in the United States and Canada, and is responsible for accrediting these schools. Some 1,000 educators, and other interested persons in the social welfare field, from schools, organizations, public and voluntary services throughout the United States and Canada attended. Many persons taking part in the sessions had varied and interesting backgrounds in the development of social work education in North America and several under-developed areas of the world.

The conference examined the implications for social work education of rapid social change in the "sixties". The points of departure for discussion were expressed in the questions: "To What Purpose Are We Educating?", "Whom Are We Educating?" and "How Are We Educating?". The opening address, "Economic And Social Consequences Of Technical Change And Their Impact On Human Well-Being", served as a broad framework for subsequent consideration of new directions social work education must take. One of the major papers, "Issues in Social Work Education—New and Changing Demands Made of the Profession", was presented by Doctor Eileen Blackey, Dean of the School of Social Welfare, University of California. The paper dealt with the issues in social work education deriving from the profession's efforts to keep pace with the revolutionary changes brought about by unprecedented advances in scientific, social, economic and political thought; and, more particularly, its attempts to deal with these issues within the frame of reference of the profession's values as they relate to the impact of change on the human and social condition. A major issue in social work education, pointed out by Dr. Blackey, is the question of how to prepare graduates to function in a world of rapid change. This requires better qualified and more creative teachers in

schools of social work. The paper at the closing session, "Legislation as an Instrument of Social Change", was given by Ivan C. Rand, Dean of the Faculty of Law, University of Western Ontario and formerly Justice of the Supreme Court of Canada. Opportunity was also available for conference members to participate in discussion groups on a broad range of topics related to the main theme of social work education in a rapidly changing society.

Along with the Council Meeting, celebrations marking the 50th anniversary of the School of Social Work, University of Toronto, were opened at a banquet on January 30. The speaker was Philip S. Fisher, CBE, DSO, DSC, DCL, Chairman of the Board, Southam Company, Montreal and Chairman of the Commission on Education and Personnel of the Canadian Welfare Council and past Chairman, Canadian Daily Newspaper Publishers.

The Honourable John Robarts, Prime Minister of Ontario, greeted the guests on behalf of the Province. Dr. Joseph Willard, Deputy Minister of Welfare, Department of National Health and Welfare, welcomed the guests on behalf of the Government of Canada.

Appointments

Occupational Therapy and Rehabilitation Centre—Miss **Evelyn Tipson** has been appointed Executive Director of this centre in Montreal. Miss Tipson was born in London, England, and trained in physiotherapy at the King's College Hospital School of Physiotherapy. She came to Canada in 1954 and joined the staff of the Centre where she became supervisor of the physiotherapy department. In January, 1963 she was appointed Assistant Executive Director. In her new position she succeeds Miss Constance Lethbridge, whose death last fall was a grievous blow to the Centre.

Department of Labour, Technical and Vocational Training Branch—**H. L. Clement** has been appointed Regional Co-ordinator, Field Service for the Pacific Region which includes British Columbia, Northwest Territories and Yukon. F.

will be stationed in Vancouver in the Old Federal Building, 325 Granville Street.

A seasoned veteran in the field of technical and vocational education, Mr. Clement has been instructor, administrator and fieldman for a number of years in British Columbia. He received his early education in Sudbury at the high school there and at the Sudbury Mining and Technical School. He has also been taking studies at the University of British Columbia, working toward the completion of a degree.

For a number of years, he was an industrial arts teacher at Campbell River and Victoria. Subsequently, he was appointed a director of vocational curriculum with the provincial Department of Education where he was responsible for the development of all aspects of curricula for technical and vocational classes and programs. In 1962, he was appointed Co-ordinator of Technical and Vocational Education for the Department of Education.

E. H. Collins is the Regional Co-ordinator, Field Services, Atlantic Provinces, located in Halifax in the Federal Building at 105 Hollis St. His work will take him to the four Atlantic provinces.

Mr. Collins has a B.A. (Biology) and an M.A. from Acadia University. He also attended the Nova Scotia Normal School. He spent a number of years in business and industry and in the Royal Canadian Air Force.

Prior to his appointment to the Department of Labour, Mr. Collins held the rank of Flight Lieutenant with the RCAF and was responsible for supervision and development of training policies.

Maurice F. J. Landry has been appointed Regional Co-ordinator for the Province of Quebec. He is a graduate of the Institute of Technology of Hull in Electrical Technology.

After several years' experience in industry, Mr. Landry joined the staff of the Quebec Department of Youth and served for approximately 25 years as teacher and director in Quebec trade schools and institutes of technology.

Prior to joining the Training Branch of the Federal Department of Labour, he was Director of the Institute of Technology in Chicoutimi. His office will be at 1100 St-Jean Street, Quebec City.

Jacob M. Varughese has taken up his new duties as Regional Co-ordinator of Training for the Province of Ontario with his office at 25 St. Clair Avenue East, Toronto.

Mr. Varughese received his B.A. and Diploma in Electrical Engineering in India and his M.Sc. from Manchester University.

After several years in industry in India and England, he joined the staff of Ryerson Institute of Technology where, since 1957, he has been teaching in the Electrical Technology Department.

Rehabilitation Institute of Ottawa Evening Program

Evening treatments have begun at the Rehabilitation Institute of Ottawa at 680 Bank St. The institute will be open Mondays, Thursdays and Fridays from 6 to 9.30 p.m. It expects about 30 physically-handicapped persons each night.

Two reasons for the evening service were given. First, staff and facilities are now taxed to the limit in the daytime. Second, many employed persons who need treatment cannot come during the working day.



Summer Speech Clinic to be Held

A summer clinic for children suffering from speech defects will be instituted next July by the University of Toronto Medical Faculty's Division of Rehabilitation Medicine.

The children will be selected from all parts of the province by travelling clinics.

The eight-week therapeutic clinic is made possible by a grant from the Atkinson Charitable Foundation.

Increase in Training Handicapped in Newfoundland

With the opening of the College of Trades and Technology in St. John's and the district vocational schools throughout the island the training program for handicapped persons in Newfoundland has been greatly expanded.

The rehabilitation division of the Department of Health reports over 70 persons, disabled by disorders including epilepsy, amputations, deafness, cardiac disorders, polio, laryngectomies, faulty vision and respiratory troubles, are receiving training in various trades to enable them to compete equally with other workers in the labour market.

This number represents more than a 100 per cent increase over former years.

A spokesman for the rehabilitation division says: "These handicapped students, upon the successful completion of their course of study, will be equal in ability and skill with non-handicapped students. They will, therefore, make a valuable addition to the labour force, being skilled in such things as auto mechanics and body work, barbering, beauty culture, carpentry, different business courses, cooking, diesel mechanics, drafting, electrical appliance repairs, radio and television maintenance and repairs, refrigeration, watch-making, welding, oil burning mechanics, stationary engineering and electronics. The contribution made by these trained individuals—and by others like them in future classes—will no doubt be a great factor in the enrichment of the general economy of the province."

New Child Study Centre to open in B.C.

A centre for teacher training, observation, and research in the behaviour and development of handicapped children opened last fall at the University of British Columbia. This is the second study centre created by UBC's Child Study Council which welds together all campus activities dealing with the study of children.

The Association for Retarded Children of British Columbia has contributed a total of \$25,000 towards the cost of opening the centre. The Williamson Foundation made an additional grant of \$5,000.

Like the council's earlier creation, the Child Study Centre for normal children, the handicapped centre will be used by UBC students in the fields of education, psychology, medicine, nursing, and social work for observation and research purposes.

Dr. David Kendall, chairman of the management committee of the centre, said the first class at the centre would enrol up to eight children aged four to seven. They will be referred to the centre through the departments of paediatrics and psychiatry in UBC's medical faculty.

All the students will be mentally retarded with IQ's in the 50 to 70 range, Dr. Kendall said. "Children with IQ's in this range can be educated," he stated, "and our aim is to explore and develop teaching methods and materials which meet the educational need of children of this type." The method developed at the UBC centre will be part of the teacher training program in the faculty of education, Dr. Kendall added, and the results of research at the centre will be carried to other parts of the province by graduating teachers.

Future plans call for the expansion of the centre in terms of numbers and types of handicaps.

"Not only will we be investigating the problem of a wide range of handicaps in the future, but there is a great deal to be done with specific groups such as the blind or the non-reader," Dr. Kendall said.

(From: Kitimat Northern Sentinel, October 1963)

Rehabilitation Offices In Canada

NATIONAL OFFICE

National Co-ordinator,
Civilian Rehabilitation,
Department of Labour,
OTTAWA, Ontario.

PROVINCIAL OFFICES

Provincial Co-ordinator of Rehabilitation,
Department of Health,
Post Office Box 5250,
ST. JOHN'S, Newfoundland.

Deputy Minister,
Department of Welfare and Labour,
CHARLOTTETOWN, Prince Edward Island.

Provincial Rehabilitation Co-ordinator,
Department of Public Health,
Post Office Box 488,
HALIFAX, Nova Scotia.

Director and Co-ordinator of Rehabilitation,
Department of Health,
FREDERICTON, New Brunswick.

Physically Handicapped Division,
Department of Youth,
9175 St. Hubert Street,
MONTREAL 11, Quebec.

Provincial Co-ordinator of Vocational Rehabilitation,
Department of Public Welfare,
85 Eglinton Avenue East,
TORONTO 12, Ontario.

Provincial Co-ordinator of Rehabilitation Services,
Department of Health,
Kennedy & York,
WINNIPEG 1, Manitoba.

Provincial Co-ordinator of Rehabilitation,
Health and Welfare Building,
REGINA, Saskatchewan.

Provincial Co-ordinator of Rehabilitation,
Department of Public Welfare,
109th Street and 98th Avenue,
EDMONTON, Alberta.

Rehabilitation Co-ordinator,
Department of Health Service and Hospital Insurance,
828 West 10th Avenue,
VANCOUVER 9, British Columbia.

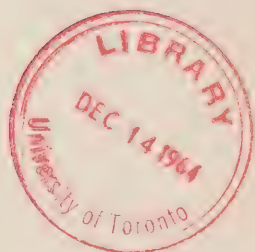


**FOR
ABILITY**

HIRE THE HANDICAPPED

UMMER

1964



Rehabilitation **IN CANADA**



Published in the interests of Canada's Disabled by ...

CIVILIAN REHABILITATION

Department of Labour Canada

ISSUE No. 8

CONTENTS

Page

- 4 National Advisory Council
- 7 Problems of the Disabled in an Industrial Society
- 13 Tuberculosis in Canada in 1964
- 15 Rehabilitative Aspects of a Hospital Clinic
- 19 The Medical Aspect in a Sheltered Workshop
- 25 Vocational Rehabilitation of Older Disabled Persons
- 27 Handicapped Persons Business Flourishes
- 30 Atkinson Foundation Helps in Rehabilitation
- 31 People and Events

This bulletin is prepared by Civilian Rehabilitation, Department of Labour, with the co-operation of the Department of National Health and Welfare, the Department of Veterans Affairs, the National Employment Service and governmental and private agencies interested in the rehabilitation of Canada's disabled.

Vocational rehabilitation represents the highest level of our social attitudes toward our fellow men. We have moved from the completely selfish 'survival of the fittest' philosophy of primitive man—through the 'custodial' philosophy which accepts responsibility for giving care and protection to the weak, the handicapped, the unfortunate—to arrive at the nobler conception of giving back to the unfortunate, the opportunity to become self-sufficient.

Mrs. Louise Taylor,
Director,
State Department of Licenses,
Washington.

To Our Readers

The Canadian Conference on Social Welfare which was held in Hamilton in June had for its subject "Welfare Services in a Changing Technology". Automation and its impact on society is receiving much attention by students, researchers and persons concerned with manpower developments in this country and around the world. Technological changes will influence the work of rehabilitation and will have decided implications for the prospects of disabled persons in the labour market. Since this is a subject of such wide interest we bring you in this issue excerpts from one of the papers presented at the conference.

During recent years great advances have been made in the treatment of tuberculosis. New drugs have done much to remove the fear of the "White Plague" from the minds and hearts of people. Nevertheless, it is well to remember that tuberculosis is by no means conquered. The article by Dr. Jeanes of the Canadian Tuberculosis Association is a timely warning that constant vigilance is the price we pay for relative control of the disease. He reminds us that there is still much work to do in the fields of detection and prevention. Rehabilitation services are still required by many who are unfortunate enough to contract the disease.

THIRD MEETING, NATIONAL ADVISORY COUNCIL ON THE REHABILITATION OF DISABLED PERSONS

At the third meeting of the National Advisory Council on the Rehabilitation of Disabled Persons, held in Ottawa on May 25 and 26, Council members expressed the belief that unemployed handicapped persons should be entitled to the same scale of training maintenance allowances as the able-bodied unemployed.

The Council recommended that:

—The federal government should undertake a study to determine staff requirements and policy changes to improve National Employment Service capability for placement services for handicapped persons, and that similar studies should be undertaken at the provincial level.

—Assistance coverage for the disabled under the Vocational Rehabilitation of Disabled Persons Act should be expanded to include the socially handicapped.

—The federal government should contribute to capital and operating costs of sheltered workshops, under the Vocational Rehabilitation of Disabled Persons Agreement.

—Academic training of adult handicapped that could lead to further vocational training should be assisted by the federal and provincial governments in a joint cost-sharing program providing for tuition and maintenance, and for transportation costs for individuals who must be brought to a centre where training can be provided.

Chairman's Remarks

"The Government's part in social welfare and cultural activity does not detract from the scope, meaning and effectiveness of professional work in private agencies, nor does it eliminate the need for experiment and service by voluntary groups," said Brig. James L. Melville, Council Chairman, in opening the meeting.

Referring to the slowly but steadily rising number of Canadians who had been rehabilitated in recent years, Brig. Melville went on to say that the primary concern in this field today was to

ensure that the services of vocational rehabilitation were made available to all of the many people who could benefit from them.

Dr. George V. Haythorne, Deputy Minister of Labour, in his remarks welcoming the members said he had been pleased to note that in the past year there had been further expansion of the federal-provincial vocational rehabilitation program, and that we now had knowledge of a large body of Canadians who, in spite of serious handicap, had been re-established as useful members of society.

"You are well aware of both the humanitarian and economic advantages that have come from your efforts." To achieve its full significance, the program for which Council was responsible had to be regarded as an important part of the fight against unemployment and dependency, he said.

Report of National Co-ordinator

Ian Campbell, National Co-ordinator, Civilian Rehabilitation, said the deliberations of the Council were assuming greater importance than ever before. In the past year, as the economy had expanded and as employment opportunities increased, there had been much evidence that a concern with the health, welfare and employment of our people were becoming deeply concerned that positive action be taken in a vigorous effort to reduce the incidence of dependency throughout Canada.

"As we endeavour to translate concern into action," Mr. Campbell continued, "we must determine ways in which the principles of vocational rehabilitation can be used in Canada to the best purpose."

The provision of counselling, medical, social and vocational assessment, followed where indicated by services of restoration, training and placement, were essential ingredients of any program to re-establish those who had difficulty in assuming their proper place within the labour market.

These services were already incorporated by legislative authority within the Vocational Rehabilitation of Disabled Persons Act, but to avoid duplication of effort and competition for scarce resources and trained staff, consideration could be given to broadening the application of the Act so that, in co-operation with other government and voluntary agencies, a vigorous campaign could be developed to promote self-reliance and independence.

Mr. Campbell went on to say that it had been encouraging to note that since the passing of the Vocational Rehabilitation Act in 1961, there had been a steady increase in the number of individuals who had benefited from rehabilitation services and had been enabled to look after their own needs.

Unfortunately, he added, the growth had not been even across the country and the number served was still but a small fraction of those who needed rehabilitation services.

Placement of Disabled Persons

In his report on the placement of disabled persons, C. A. L. Murchison, Commissioner, Unemployment Insurance Commission, emphasized the importance of selective placement.

He drew attention to the fact that selective placement did not end with the actual placement of a handicapped person; a follow-up had to be made to see that the individual had secured a proper adjustment in his position. At the outset, Mr. Murchison had stated his preference for the term "handicapped" over "disabled", as the latter connoted a finality.

He reported that the National Employment Service had increased its staff of Special Services Officers, who were active in selective placement, but that it had not yet been possible to fill numerous openings.

During the fiscal year 1963-64, Special Services Officers of the NES had selectively placed a total of 18,457 handicapped persons in the 10 provinces. All of these were individuals who required a certain degree of presentation to employers. These officers had conducted some 119,000 counselling interviews during the period.

Medical Rehabilitation

A report from the Medical Rehabilitation Division, Department of National Health and Welfare, prepared by Dr. K. H. Running of the Division, was presented to the Council.

Expenditures under Medical Rehabilitation and Crippled Children Grant funds for 1963-64 increased by some \$200,000 or about 8 per cent. The report underlined the importance of having adequate rehabilitation staff, and reported important progress here.

A new school of physiotherapy was formed last fall at Dalhousie University, sponsored jointly by Nova Scotia, New Brunswick, Prince Edward Island and Newfoundland. A school of occupational therapy is also said to be in the planning stage to alleviate acute personnel shortages in the Maritime Provinces.

A new school of physiotherapy is being planned for the University of Saskatchewan and possibly one or two more are projected for other areas in Canada. Further, a new school is planned for Laval University.

The report also dealt with speech therapy, and described as well the work of three special centres and of special courses organized in 1963 following a report by the special committee on thalidomide deformities.

The Division's report pointed out that, since 1960, the number of approved projects has grown from 38, receiving some \$750,000 annually, to about 100 projects in 1963, receiving assistance of some \$2,000,000.

Motions Presented

Three motions on medical rehabilitation, prepared by Dr. Gustave Gingras, Executive Director, Rehabilitation Institute of Montreal, were presented to the Council. In essence, they proposed that:

—The Council should continue to press for duty-free entrance into Canada of certain essential rehabilitation appliances, equipment and self-help aids.

—The Council and certain other affected bodies should press for the establishment of registries of disabilities and disabled persons in all provinces of Canada.

—The Council should recommend that "the excellent service" now provided by the Depart-

ment of Veterans Affairs in filling prosthetic needs of veterans, the extent of which would decline in the future, be transferred to some other responsible organization so that "it may be maintained and expanded for the benefit of all Canadians."

All three motions were passed by the Council.

Report of Provincial Co-ordinators

The Council was presented with a report by the Provincial Co-ordinators of Rehabilitation, arising from a meeting they held in Ottawa on May 21 and 22. They suggested certain changes in the federal-provincial Vocational Rehabilitation of Disabled Persons Agreement, and in Program 6—Training for the Disabled—of the Technical and Vocational Training Agreement.

Several recommendations by the Provincial Co-ordinators resulted in resolutions by the Advisory Council.

National Employment Service

A resolution concerning NES responsibilities under Schedule 4 of the Vocational Rehabilitation of Disabled Persons Act proposed that the federal Government undertake a study to determine staff requirements and policy changes to increase NES capacity for placement of handicapped persons, and that similar studies should be undertaken at the provincial level.

It was pointed out in discussion that this resolution did not constitute a criticism of the NES. Mr. Murchison informed the Council that the staff of Special Services Officers had been increased but that some offices still did have such a staff.

The resolution was passed.

Training for the Socially Handicapped

The physically and mentally handicapped have been subject to much successful vocational rehabilitation. It was suggested that some of the socially handicapped—those dependent on welfare and the long-term unemployed—could also benefit from these services. Extending the services of rehabilitation to these individuals would seemingly require no change in legislation and the Advisory Council recommended that the government consider such extension.

Sheltered Employment

Another resolution adopted by the Council recommended that the federal government contribute to capital and operating costs of sheltered workshops under the Vocational Rehabilitation of Disabled Persons Agreement.

On sheltered employment, the Co-ordinators' report also undertook to define and describe sheltered employment in terms of work assessment and work training.

It proposed that costs of providing sheltered employment facilities and operating them be shared by the various jurisdictions. For example, capital costs should be shared equally by three jurisdictions: the federal and provincial governments, and the voluntary agency or local public jurisdiction.

Further, it was suggested that all federal funds for sheltered workshops be channelled through the provincial rehabilitation authorities.

In the discussions on sheltered employment Mr. Campbell stressed the importance of this phase of rehabilitation, especially where it constituted an important transitional period to regular employment.

Academic Training for Adult Handicapped

The Council passed a resolution to the effect that the academic training of handicapped persons could lead to further vocational training should be assisted by the federal and provincial governments in a joint cost-sharing program. Such a program would provide for transportation costs and living allowances for individuals who must be brought to a centre where training can be provided; in cases where the individual is above school age, costs of tuition, maintenance and transportation should be shared.

The Provincial Co-ordinators had pointed out there were occasional cases where a handicapped person over 21 years of age required a full year of academic education before he could apply for admission to technological or university training. The existing provision for cost-sharing for vocational university training should be interpreted to accommodate such cases, it was suggested.

Additional Reports

A "Report of the Medical Committee on Early Referral of Treatment Cases to Vocational Rehabilitation" was presented by its Chairman, Dr. O. Hoffman, Chief, Medical Rehabilitation Division, Department of National Health and Welfare.

The Medical Committee suggested that:

—There be adequate assessment and review of recipients of social assistance for rehabilitation potential, and that an appropriate rehabilitation report form be used by welfare departments for all applicants having a health problem.

—There be development of registries of crippled children and adults, employing standards common to all provinces, with periodic review of registries for the identification of rehabilitation candidates.

—Medical data on applicants for disability allowance be provided to rehabilitation and registry services for identification of possible candidates for rehabilitation.

—There be developed in general hospitals a rehabilitation committee composed of the appropriate medical and para-medical staff, including medical social service, and that the committee have primarily a case finding function, to assure that all patients, including outpatients, who can benefit from rehabilitation procedures are referred to the appropriate community resource.

—Vocational rehabilitation counsellors be assigned to regular visiting of hospitals.

—The National Employment Service be included in all planning relative to rehabilitation programs at community level, and . . . that the Special Services Officers (Placement) work directly with the rehabilitation programs.

Another report, on the training of disabled persons under Program 6, was given by W. J. Hurd, chief of adult trade and occupational training and retraining, Technical and Vocational Training Branch. It reported that:

—A total of 3,345 handicapped men and women took training last year, compared with about 1,200 in 1958 and fewer than 700 under similar programs in 1954.

—A total of 224 training-on-the-job contracts were arranged last year.

—The education of retarded children is gaining more attention through a few vocational training programs for them under program 6.

—Many new schools that have been built incorporate facilities for handicapped persons.

In a report submitted by the Civilian Rehabilitation Branch, it was revealed that in the past fiscal year, a total of 2,134 individuals had been rehabilitated. Of this total, 2,038 had been able to return to regular employment.

The cost of maintaining these individuals and their 1,684 dependants had amounted to \$1,363,065 a year. Now, after rehabilitation, their collective earnings are \$4,245,004 a year.

PROBLEMS OF THE DISABLED IN AN INDUSTRIAL SOCIETY

By

VALERIE A. SIMS, M.S.W.,

Civilian Rehabilitation, Department of Labour, Ottawa

(Extracts from a paper presented at the Seminar on the Working Environment at the Canadian Conference on Social Welfare, Hamilton, Ontario, June 2-5, 1964.)

This paper is concerned with those disabled persons who, because of physical, mental or emotional impairments, are handicapped in obtaining or continuing in employment. The industrial society presents problems often more difficult for the disabled to solve than for others. I would like to discuss five of these problems which I think are of major significance. These are the

problems of change, of choice, of working, of the job and of attitudes.

I. Problems of Change

The industrial society is characterized above all by complexity and rapid change. Occupational changes which have taken place affect the labour market as a whole and thereby, the number and

kinds of job opportunities for the handicapped. Over the past 30 years and particularly since 1950, the most significant changes have been: a rapid increase in white-collar and service occupations (from almost 35 per cent of jobs in 1931 to 50 per cent in 1961); a relatively slow growth in the manual occupations (these occupations accounted for a third of the labour market in 1931 and just over a third in 1961); a decline in unskilled labouring from 11.3 per cent to 5.4 per cent and a very severe decline in the primary occupations of agriculture and fishing (65 per cent of the labour force was engaged in primary occupations in 1931 but by 1961 only 26 per cent were so occupied).¹ With the expansion in the proportion of capital equipment to labour there has been a marked increase in the actual productivity of the labour force. There has also been a reduction in the length of the working day, the working week and the working year. There has been a massive shift of population from rural to urban settings, particularly with the application of scientific methods to agriculture. This shift of the labour force from manual occupations into the technical, clerical, managerial, skilled and service occupations is expected to continue with increasing technological development.

Effects of occupational changes. Many of the effects of these changes which have taken place over the past 40 to 50 years, but at an increasing rate recently, can already be seen. With higher skill requirements for more jobs, the necessity for higher levels of education and training becomes more urgent. There is a consequent decline in emphasis on muscle power and physical fitness. Further technological development and automation may have the effect of changing occupational requirements even further, toward a demand for flexibility, alertness and adaptability on the part of the worker. Little is known so far about the effects of automation, a more dramatic aspect of fundamental technological change and there is little agreement about its future impact on occupational requirements.

Automation. Automation has not been introduced widely enough yet for any firm conclusions to be drawn, but there are indications that, as industrial processes become more integrated as a result of automation, it will not be enough for a worker to equip himself with a specific but

limited skill to last a lifetime. He will probably need the ability to move and adapt to change and in some cases he will be required to understand a whole industrial process rather than one small element of it. We do not yet know the answers to many questions posed by automation, but we are aware that the industrial society has been, and is, undergoing a rapid and fundamental technological change of which automation is but a particularly outstanding aspect. We also know that such changes do not take place without considerable dislocation and friction. Today, jobs requiring skilled manpower go begging while the level of unemployment remains at 5 to 6 per cent. More of the unemployed are younger or older than the employed. They are more apt to be unskilled and poorly educated and they tend to live in areas bypassed by industry or where industrial production has been cut back. There is thus a dislocation between supply and demand in the labour market.

Future trends. Looking ahead we can see an increase in the professional and technical personnel; engineers, scientists, doctors, lawyers. Semi-skilled workers should rise at about the same rate as the increase in the total labour force but the demand for unskilled workers is not expected to increase at all. All this points up the increasing need for educational and training requirements for employment. Case studies on the impact of automation tend to substantiate the overall picture. For example, at July 1, 1962 there were 3,437 people employed in full-time computer jobs in Canada, an increase of three times the number reported only 18 months previously.² American studies have found that the introduction of computers opens new job opportunities at the top of the office grade structure while the jobs that are eliminated are the routine clerical posts.

Consequences for the disabled. What are the consequences for the physically handicapped, the mentally retarded and the emotionally disturbed in such an environment?³ Some of the changes which I have outlined are of advantage to the employment of the disabled. Technical advances greatly reduce the emphasis on physical strength as a job requirement. Semi-automatic machines may be easier to adapt to the special problems of the physically disabled. The increasing demand for workers in service occupations provides oppo

tunities in which physical disability may not be a primary obstacle. Reduction in working time eases the constitutional demands on the physically disabled. Hoped-for improvements in town planning may also make it easier for many of the disabled to get to work.

However, there are some probable disadvantages in the train of technological change. If technical advance does bring lay-offs, the handicapped who have only recently been able to enter the labour market may be the first to be fired because of lack of seniority. The much greater demand for adaptability of the labour force, for job mobility and for constantly acquiring new skills in a rapidly changing technology, could pose a problem for some disabled persons, although there is no evidence to indicate that the physically handicapped are less adaptable than other workers.

A heavy burden would certainly fall on the mentally retarded as unskilled jobs decline and higher education and adaptability is demanded. There has been a tendency to prepare the mentally retarded for the simple, repetitive type of occupation. These jobs are declining and so perhaps we should be preparing them, where possible, for some of the service occupations. Some very encouraging steps have been taken in this direction already. Above all, the very complexity of the changing industrial society poses a particular problem for those who have not worked before or who have serious handicaps to overcome before they can work.

I. The Problem of Choice

Our industrial society presents a sweep and variety of choice for individuals in work, in leisure, in learning and in new experience which can be baffling. Paul Samuelson, Professor of Economics at the Massachusetts Institute of Technology and author of a standard text on economic analysis, starts his study of the technological society with the problem of choice. He expresses the heart of this problem when he says, "In the world as it is, even little children are supposed to learn in growing up that 'both' is not an admissible answer to a choice of 'which one'".⁴ The very act of choosing is difficult and frightening, particularly for the disabled whose opportunity to choose is often limited. Where everything is

moving, wisdom and safety appear to reside in sitting still. And yet, because the possibilities are there, so many people cannot feel settled in a world of change. To choose is to be unsettled, but not to choose is also to be unsettled.

For most disabled persons it is important to choose an occupation carefully. Because of the limitations imposed by disability, it is often not easy for them to change jobs or to take a succession of odd jobs. It is usually better if they can be settled in a more permanent job which they are trained and qualified to perform. However, because of the complexity of the occupational field today, help is usually required by the disabled person in making a suitable choice of occupation. The average individual is not in possession of the essential facts about different occupations and their requirements, yet without this information it is very hard to decide which jobs are most suitable.

The problem of choice also arises in vocational training. The disabled person must not only choose a training which he can do, but he must have a reasonable assurance that such training will lead to the "best" occupation for him. He must also have an idea of the demand for people with the training he is contemplating. These choices must be made by the non-disabled entering the labour market too, but if additional limitations are imposed by disability, the satisfactory solution of these problems of choice becomes more urgent. Also, if the wrong choice is made, or if a plan does not work out, it is generally harder for the handicapped person to find a new job.

The significance of services of vocational counselling and selective placement becomes evident in the complex occupational world we have today. It is almost impossible to make a good choice of occupation without the aid of expert advice. A new expertise is required to interpret the industrial society and its requirements to those whose well-being may well depend on making the right choice. Whether such expertise is acquired by placement officers, vocational counsellors, social workers or some as yet unknown profession is not as important as the fact that this service is very badly needed to reduce the dislocation between supply and demand and to moderate the

harmful influence of rapid change on a less rapidly changing labour force.

If the disabled cannot make these essential choices they will be reduced to "sitting still", to not choosing. This, to me, is the essence of what is meant by "making more opportunities available in the life of the disabled person". It is making it possible to choose, as well as broadening the area of opportunity from which to choose.

The problem of choice is a second aspect of the industrial society, related to, though not identical with, the problem of change. It has particular consequences for those whose ability to choose is limited.

III. The Problem of Working

For those who have had little or no previous working experience, the requirement of work, rather than the job itself, is often the major problem to be dealt with. This is particularly true, for example, of the seriously crippled child who has lacked some schooling, who has been over-protected by his parents and who has missed out on many of the normal experiences of other children in growing up. On reaching working age he may lack an adequate level of education to qualify for a job which his physical capacities would otherwise permit him to do. If he has not been able to learn a skill his entrance into the labour market will be even more difficult. These are serious problems, but in many instances they can be reduced through educational upgrading, training and adequate vocational preparation as the child grows up. What is harder to overcome is his unpreparedness for the experience of work itself. Because such disabled young people have missed the full experience of living, they lack some of the basic skills of social existence and so they lack some of the essential requirements for work.

The mentally ill in the working environment. This problem of work experience is a serious one for the mentally ill. In the mental health field, the fresh winds of change blowing through our mental institutions are literally returning patients to life and reality. Men and women are coming out of hospitals after 15, 20 and 25 years. We are talking of life in the community for them; even of jobs for them. Our first thoughts might be of providing training in a skill so that such a person can get a job. He probably could be taught a skill

and perhaps he has one already, learned in the hospital. That is not the major problem he faces in the industrial society and in the world of work. If we find him a job, he probably has to take a bus to get there. Chances are he has never seen a bus. He must buy his fare and pay for his coffee in the canteen; but has he ever handled money in his life? He must spend eight hours a day with people who will treat him like everyone else and expect certain behaviour of him, but he has only been treated as a patient and has had no responsibility. He is expected to work these eight hours but he has probably not built up the tolerance to do so and possibly the idea of such regularity is completely unfamiliar to him.

Experience of working a problem for other disabled. The effect on the mentally ill, and persons long institutionalized, of the overwhelming complexity of the working environment after institutional life, is an extreme example of the problem faced by many disabled persons in employment. It is a problem met in varying degree by anyone whose disability has diminished his life experience. Even those who have had a so-called normal life and have worked before, find it very difficult indeed to assume the routine of a job after prolonged illness or time away from work due to injury. I am sure there are very few counsellors or social workers in the vocational rehabilitation field who have not had a client for whom everything seemed prepared and many obstacles conquered, but the client didn't work because the habit of getting up in the morning, finding clothes to put on, eating and getting out of the house by eight o'clock was an insuperable obstacle when it had not been required before.

Architectural and physical barriers. Another problem is posed for the disabled by the physical environment of our society and this problem appears in the working environment as an obstacle to employment. I was recently told about a paraplegic, a man paralyzed from the waist down and confined to a wheelchair, who had been trained as a skilled precision machinist. He located a very suitable job, many difficulties had been overcome, transportation to work was arranged and he was ready to start work. But he didn't get the job because the door to the workshop was too narrow to admit his wheelchair.

Architectural barriers of all kinds are a serious problem for many disabled persons and have ve

often been the one preventing factor in an otherwise fine plan to start work. Architectural features taken for granted and often admired by the majority, serve to diminish the disabled person's opportunities for work and enjoyment of community activities. Fortunately, something is being done to help alleviate this problem through a new committee of the National Building Code, established to introduce building standards designed to avoid these and other less obvious architectural injustices.

IV. Problem of the Job

What of the job itself? Evidently this is a general question as I do not think this is the time to go into the characteristics of particular occupations and their requirements. Occupational information is part of the knowledge required by vocational counsellors and placement officers, as mentioned earlier. However, there is another reason why I am not raising the question of particular jobs for various categories of disabled persons. Some stereotyped ideas are still current about occupations suitable for the disabled—ideas of specific disabilities being associated with specific occupations; such as watchmaking for wheelchair cases. Attempts have even been made to assign lists of various occupations to matching lists of disabilities. Apart from the obvious fact that employers do not hire disabilities, but hire persons with the skills needed to do the job, such an approach is unrealistic, because the disability is not what characterizes the individual. There are as many individual differences among the disabled as there are in the whole population. This is not to discount the disability, which would be wrong, but it is what the disabled person can do which is the realistic basis for choosing suitable occupations.

There is ample evidence to show that the range of occupations carried on by the disabled is as broad as the number of occupations which exist. It is true, of course, that certain jobs are not possible for persons with certain limitations, but assigning jobs on the basis of disability has never been very successful and is a very narrow approach to the problem. A word might be said here about the retarded. In the past 10 years, much has been done for the mentally retarded and their social and vocational preparation. However, the

problems confronting the retarded in the working environment are still overwhelming. Early identification and adequate assessment of the retarded is essential if they are to be enabled to become self-sufficient in any measure at all. Experience has shown us that even the quite severely retarded can, with patient and careful preparation and training, perform quite a variety of tasks. To translate the abilities of the retarded into actual jobs is not easy. As we noted earlier, the types of simple, routine, repetitive jobs which they can do, and for which they are presently being prepared to a large extent, are the very occupations which are declining in the labour market. I think that one of the major problems for the retarded in the working environment rests in the shortage of suitable jobs which they can perform.

The ability to perform a job is determined by intelligence, experience, training, skill, dexterity, aptitude, interest, motivation and many other characteristics. It is these factors which help to determine the type of work which anyone can do. Disability becomes a factor when it interferes with the acquisition of this background, when it imposes limits on working ability or when it sets the individual at a disadvantage in the employment market alongside the non-disabled.

V. The Problem of Attitudes

The last major problem encountered by the disabled in the working environment which I would like to put forward is in the area of seeking employment. It is the problem of attitudes. For one thing, some employers do not want to hire the handicapped. Sometimes it is because the employers, too, see the problems which I have already mentioned. In many industrial undertakings the exigencies of production do not allow much time or flexibility for a disabled worker to adjust to the experience and demands of work. Also, the idea that complete physical fitness is required for almost all jobs is still deeply ingrained. While it has been demonstrated over and over again that, with little or no modification to a machine or to the working environment, a disabled person can perform a task just as well as a non-disabled person, it is still very hard to sell this idea.

Ergonomics. The design of work in the light of information about human performance is called

ergonomics, or how to fit the job to the worker. There is really no reason why any firm, however small, should not employ the ergonomic approach to the employment of disabled workers. A few of the work limitations which a physical disability might impose are: limited movement of lower limbs; limited movement of arms; no bending, stooping, lifting or carrying; work in quiet conditions only; no close visual work; no dust, fumes, etc. and that catch-all, "light work only". Studies in ergonomics⁵ have found that many jobs can be slightly modified to meet these and other requirements. Engineers and designers are not lacking in ideas. Even minor re-organizations within a company will bring apparently heavy jobs within the scope of physically disabled workers. A large source of manpower then becomes available to the firm. If the engineers are told what is required, they can usually be expected to produce it. But the firm itself must be willing to take this approach. If there is a labour shortage, of course, firms are much more willing to explore these possibilities. But it is essentially a question of attitudes and I do not think we have progressed very far in this area in Canada with respect to the disabled.

Welfare. Past attitudes in public welfare, happily changing, which concentrated on categorically administered pensions as practically the only alternative to economic self-sufficiency for the disabled, discouraged efforts to develop ways and means of improving the disabled person's assets so that he could have a chance of working. In any situation where minimum wages and welfare benefits are at about the same level, a very vexing problem develops as the maintenance of adequate levels of welfare benefits becomes a disincentive to employment. These situations strike the disabled who are marginally employable or whose pensions have earnings ceilings attached. These pensioners tend to work (if they do work) up to the point where their pension starts being reduced. Then they hold that level for there is no further incentive, and much worry about loss of pension. I think this problem is related to attitudes of society towards economic dependency, but I do not think it is the whole story. It is certainly a very difficult problem and cannot be solved by the welfare field alone.

Quota Systems. I know that in many countries quota systems, which require employers to hire a certain percentage of disabled persons, have been introduced in an attempt to overcome some of the disadvantages encountered by the disabled in obtaining employment. The experience of some quota systems has been that they tended to downgrade the disabled person and to perpetuate the idea of a second-class group of citizens. Canada's position at the International Labour Organization has been that, while quota systems may be appropriate for conditions in some countries, member nations of I.L.O. should be free to adopt the approach to the employment of the disabled best suited to their own particular conditions. Canada's approach has been, so far, that it is preferable to develop services for the vocational preparation and employment placement of the disabled on the basis of their abilities. While progress is admittedly slow, it still seems to me that this is the more positive approach and has a better chance of dealing successfully with the problem of attitudes.

In the industrial society the disabled will continue to encounter problems. If there is change, people must adapt. When there are alternatives, choices must be made. So long as work is a part of life, people must learn how to exist in the working environment. As houses, buildings and factories are built, physical obstacles are created. If there are jobs to do, people must be trained to do them. Finally, throughout this whole complex society attitudes to the disabled will be encountered, sometimes hindering, sometimes helping to find solutions to these problems.

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TUBERCULOSIS IN CANADA IN 1964

A CONTINUING CHALLENGE TO REHABILITATION

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Canadian Tuberculosis Association

The World Health Organization chose tuberculosis as its disease of the year in 1964 and selected as the theme "No Truce for Tuberculosis", "Pas de Trêve Pour la Tuberculose". This choice by the WHO should serve to emphasize that this disease is still of extremely serious significance throughout the world and still remains a problem of some considerable magnitude even in Canada.

The incidence of new cases of tuberculosis and the death rate has been slowly falling throughout this century. The advent of the wonder drugs, streptomycin, PAS and isoniazid in the early 1950's produced some effect on this rate of fall, with well-marked diminution in the death rate but very little effect on the new case rate. However, the whole outlook for the individual patient with tuberculosis was altered by the chemotherapeutic drugs because his treatment could be carried out much more quickly and, provided he completed the full two years of drug treatment which is still necessary, he was assured of a very high chance of permanent cure of his disease.

Problem of Complacency

However, because these drugs took the terror out of the disease for so many people, and their relatives, we in Canada, as in many other countries, have been faced with the problem of complacency. Unfortunately, tuberculosis is regarded by many people as a disease that no longer exists. How wrong they are. Well over 6,000 new active cases are still being diagnosed in Canada each year. It still takes at least six months in hospital to treat the person with an average early case of disease. Then the individual must carry on with his drug treatment for a full two years to be reasonably assured of permanent cure.

Intense mass X-ray and tuberculin surveys have been carried out in Canada for over 20 years. In an average, very well organized survey of a community it is possible to reach between 70 and 80 percent of the population who ought to be X-rayed. It is an unfortunate fact that at

least 20 per cent of individuals in any community do not avail themselves of the services of mass surveys. It is also well-known that it is in this group of individuals that the highest incidence of tuberculosis exists. It is, unfortunately, all too common for active tuberculosis to be diagnosed in an advanced state in an individual by his family doctor in a district where a mass X-ray unit was in operation only weeks or months beforehand. This is always extremely sad, because it means that the individual's chances of a permanent cure are diminished because of the extent of his disease and, of course, his cure will take longer. It must also be remembered that tuberculosis is an infectious disease and the ambulant infectious case may well have endangered other people in the community.

Fighting Disease

Tuberculosis can only be controlled and eventually eradicated by finding every active case and treating it, and by providing adequate supervision for all old cases. The tools for diagnosis are available everywhere, but these tools are only as good as those who use them. This involves the proper use of X-rays in surveys, concentrating particularly on high incidence groups, although the open community survey done every four or five years is still of value almost everywhere in Canada. Coupled with the community or special group survey, the tuberculin test has become a very important screening method in recent years because it indicates those individuals in the community who have been infected with the germ of tuberculosis and who therefore need more careful supervision in the future. With modern drug treatment and the shortening of time in sanatoria there has been a great change in emphasis in treatment. The patient now needs to spend approximately one-quarter of his treatment time in hospital or sanatorium. The remainder of his treatment can be carried out at home, often after his return to work.

Modern treatment of tuberculosis with drugs has been remarkably successful and has improved the outlook for so many patients. At the same time modern technology is having an effect on the types of occupation in today's labour force, with an increasing demand for higher skill. Concurrent with this changing labour situation, tuberculosis is proportionately becoming a disease of older age groups, principally men over 50 years of age. Late diagnosis of tuberculosis in these older workers, who are often able to do only unskilled work, which is frequently far too strenuous for them to return to, does present great problems.

Rehabilitation Groupings

In considering rehabilitation of the tuberculous, patients can be divided broadly into three equal groups. The first group of patients have only minimal or moderate tuberculosis which can be brought under control with drugs in a matter of a few months only. Most of these individuals can return to their former occupations with little or no restriction placed upon their activity. Long term rehabilitation programs for such individuals are not indicated. However, it is certainly wise for many individuals in this group to take advantage of the opportunity to add to their occupational qualifications during the several months they must spend in hospital.

The second group of patients are those with moderately advanced or far advanced tuberculosis requiring long term hospital and drug treatment. A few of these will be able to return to their former occupations when their treatment has been successfully completed. However, many of them will have had unsatisfactory jobs prior to being taken ill, very often jobs to which it would be quite unsuitable for them to return. These constitute a very large group of individuals who can benefit considerably from the services of the rehabilitation officer in assessing needs and capabilities and arranging for the appropriate courses of retraining. There are many individuals in Canada who, as a result of having had tuberculosis and being promptly started on a rehabilitation course have, at the end of their treatment, been able to re-establish themselves in much more satisfactory positions in life than before disease was diagnosed. Many of these individuals are

walking tributes to well arranged rehabilitation programs.

There are a few individuals in this group who, for lack of mental ability, cannot be trained for better positions. They very often present a great problem and a challenge to the employment services to find suitable menial tasks in the community where mental ability is not necessary. Unfortunately, the jobs for these completely untrained people are becoming fewer and farther between and of course when placed, they are very often in dead-end occupations.

The third group of patients presents physicians, nurses and rehabilitation officers with the greatest problem in control. These are the unsatisfactory members of the community who frequently are admitted with advanced disease, who settle down most unwillingly to treatment, are extremely difficult about taking their drugs, often discharge themselves from more than one sanatorium and all too commonly have some related problem such as alcoholism. Unless we are able to control them, to complete their treatment satisfactorily and to re-establish them in some sort of reasonable position in the community, we will never eradicate tuberculosis. It is from this group of individuals that the reservoir of infection in the community is being maintained and they do present a great problem in rehabilitation. As every rehabilitation officer knows they need the most careful assessment and handling in an effort to win their confidence. Constant vigilance and supervision is necessary during any course of training and rehabilitation. Unfortunately, however hard and dedicated one's work is in respect to so many of these individuals, the long term results are often disappointing as they all too easily drift away from the best planned programs. However, such individuals do present a constant challenge. The rescue of even a few from this state of chronic poverty and degradation is such a gratifying experience that it should stimulate everyone to do his utmost for these unfortunate members of our community.

Modern Drug Treatment

Tuberculosis still remains a significant disease in Canada today. Fortunately, modern drug treatment has altered the whole outlook for most patients, many of whom can return to a completely normal life and activities with no restric

tions placed upon them. However, it is still a long term disease necessitating at least six months in hospital or sanatorium for initial treatment and as long as two years of follow-up drug treatment. Rehabilitation can play a very important part in furthering the education of many individuals who will be returning to their previous occupation and inducing them to use their time in hospital to good advantage. Rehabilitation of patients with

moderately or far advanced disease is still a very necessary part of our rehabilitation programs for ex-sanatorium patients and can produce very gratifying results. Unfortunately, there still remains a small hard core of socially inadequate individuals in the community. It is very often these individuals who are found to have advanced tuberculosis and their rehabilitation does present considerable problems.

REHABILITATIVE ASPECTS OF A HOSPITAL CLINIC

Geriatric Clinic of the Jewish General Hospital, Montreal

By H. GRAUER, M.D.

The Geriatric Clinic of the Jewish General Hospital was organized in 1955 for the care of our elderly patients and to study the phenomenon of ageing. During the past nine years we have rendered a useful service to patients and the hospital and have also gained some insight into the physical and psychological aspects of ageing.

Our clinic is an outpatient clinic, part of the Department of Psychiatry, that cares for ambulatory patients only. The aim is to provide comprehensive care for the older patient in a multi-disciplinary setting.

Too often in this age of medical specialization, the geriatric patient with multiple complaints is shifted from one speciality clinic to another, a frustrating experience both for the patient and the doctor. Elderly patients come to a hospital not only to obtain treatment for physical illness but also to get help with their emotional and socioeconomic problems and often to seek companionship and a sense of belonging. Busy out-patient departments are geared to provide medical care only.

Our philosophy is to provide medical care and to rehabilitate the ageing person who is functioning below his physical and mental potential, so that he can live independently in his community.

Organization

The clinic is a unit of the out-patient department and patients 60 and over who meet general O.P.D. requirements are eligible for clinic care. Clinic fees charged vary from no charge to \$3.00.

Most of our patients are seen free of charge or for a nominal fee. The clinic meets one day weekly and there is a morning and an afternoon section. Thirty to thirty-five patients are seen weekly. The clinic is staffed by internists, psychiatrists, social workers, psychologists, occupational therapists, nurses and hospital volunteers.

Patients are referred from other clinics of the hospital and hospitals in the Montreal area, private practitioners and social agencies; frequently, however, patients are self-referred. Referrals also come from the in-patient service of the hospital when patients are discharged.

The patient is first seen by a social worker who obtains a detailed social history from the patient and the patient's relatives. When necessary a home visit is made. Next, the patient is assessed by an internist and psychiatrist. When necessary, psychological tests are carried out. After diagnosis a course of treatment is prescribed and this is carried out by the internist and/or the psychiatrist. Most of our patients see both these specialists on subsequent visits, but when their difficulty is primarily medical or psychiatric, they may continue with the appropriate doctor only. They are referred back when new problems or complications develop. For example, a depressed patient may see the psychiatrist on subsequent visits to the clinic. If, in the course of his psychiatric treatment, a physical sickness sets in, a consultation and continued care with his internist is arranged. A personal relationship between patient and clinic staff is fostered by having the patient return to the same doctor and social worker. It is very



A group of patients pack supplies for the hospital in the Occupational Therapy Workshop of the Geriatric Clinic.

important, especially for elderly patients, to have "their own doctors, social workers and occupational therapists". This is often difficult to arrange in huge out-patient clinics.

Hub of Clinic

At first the patient may be seen weekly, later the visits are spaced and most of our patients come to the clinic once monthly, once their physical and/or emotional illness is brought under control. A patient is usually not discharged. When regular visits are no longer necessary he may be seen once every three or four months. Contact is always maintained, which is very reassuring for the geriatric patient especially if he has no family support. In this fashion our clinic can be seen as a "Well-being or prophylactic clinic".

The social service worker and the social service department function as the hub of the clinic. The

closest contact with patients is maintained on the social service level. Workers not only have contact with patients but also with members of his family. When carefully traced it is not only pain in the physical sense that brings the patient to the clinic but very frequently family conflict or social and economic problems. Stress of interpersonal relationships in crowded homes where the patient feels or is rejected by other members of his family is often noted on intake. Children in-laws, marital partners are seen together with the patient or separately by the social worker. The problems of the aged parents are explained to the children and difficult family relationships eased by mutual understanding. The social worker is also helpful in orientating the patient to utilize community resources such as Golden Age clubs, summer camps, Friendly Visitor and Homemakers Services.

A detailed description of the function of the social worker in our clinic is given by Mrs. S. Gold in her article: "Social Services in a Geriatric Setting."¹

Unique to our clinic is an out-patient occupational therapy department located in the clinic area of the hospital. This is staffed by two professional occupational therapists and a group of volunteers. A group of clinic patients meets three half days weekly. The group is composed of 15 to 20 men and women. Occupational therapy is regarded as treatment. Only patients whom we feel will benefit are referred. The group gives patients important social contact; they are taught new handicraft skills, renew old ones and also do useful work for the hospital central supply room. Clay pottery, painting and copper work, mosaics and sewing are popular. The patients seem to

derive gratification from packing tongue depressors, safety pins, gauze swabs for sterilization and subsequent hospital use. The group is of special benefit to withdrawn, isolated, lonely patients who frequently live alone, have no family contacts and have a great deal of difficulty with inter-personal relationships. These patients are often handicapped when it comes to making social contacts but are able to relate well in a working group. Our aim is to "graduate" patients from the occupational therapy workshop into Golden Age clubs or, if their motivation and working habits are satisfactory, into a sheltered workshop or in a few cases, to paid employment.

The clinic uses all the facilities which are available in a large general hospital, for example, other speciality clinics, physiotherapy, in-patient services, etc. More important, however, is our close



Patients and occupational therapists celebrate the 97th birthday of the Clinic's oldest member. Standing immediately behind his birthday cake, wearing cap, he provided a bottle of light wine which he made himself to mark the occasion.

liaison with community resources. We have worked hard to establish contacts with Golden Age clubs, summer camps which accept geriatric patients, the Sheltered Workshop of the Jewish Vocational Service, the Victorian Order of Nurses and social agencies such as the Municipal Welfare Department and the Baron de Hirsch Institute. The latter, a Jewish Welfare organization, is helpful in providing legal aid, homemaker service, emergency financial assistance, boarding home placement and counselling by professional social workers. The former provides much needed financial help.

Facilities Needed

One of our greatest needs is for more sheltered workshop facilities. The workshop of the Jewish Vocational Service provides an excellent service for our patients but their facilities in the area of terminal care are not large enough to meet our growing needs.

Recently, we established an emergency home visit service. When a patient is too ill to come to the clinic, he is first screened by a VON nurse and then is seen by one of the clinic doctors at home. Treatment is prescribed and when necessary admission to the hospital is arranged. This project is being financed by the Associate Nurses of Jewish General Hospital and, at present, serves as a pilot project for a more extensive home care programme.

Statistics

The average age of our patients is 72.1 for men and 70.2 for women. Forty-nine per cent of patients are widowed and 36 per cent married. On December 31, 1963, there were 247 active patients in the clinic. During 1963, we took in 68 new patients, re-opened 46 cases (old patients who dropped out and subsequently returned to the Clinic) and closed 11 cases (patients who died or failed to return.) Some 2,169 examinations were carried out by internists and psychiatrists. Thirty-five per cent of our patients are followed by internists, alone, 25 per cent by psychiatrists and 40 per cent by both. Women outnumber men in the clinic two to one.

Research

Our approach and research are clinically orientated. We often conduct studies to evaluate the

usefulness of certain drugs. One of the first studies on the antidepressant Imipramine was carried out in our clinic.² At present, we are in the process of evaluating a vasodilator drug to assess its usefulness in cerebrovascular disorders. For the past year we have used a punch card system to collect socio-economic, medical and psychiatric data on each patient to enable us to get a better picture of the ageing process in our clinic population.

In summary, this is a description of a special type of out-patient clinic unique in Montreal and probably in Canada, structured to assist patients over 60 with difficulties in the "ageing process" due to socio-economic, physical and/or emotional problems. The clinic uses a comprehensive approach by a multi-disciplinary team.

Our philosophy is to enhance the patient's ability to function so that he may maintain himself, for as long as possible, independently in the community. We use all the resources of a general hospital along with all available community facilities.

(Grateful acknowledgements are extended to Mrs. I. Swatek, our volunteer clinic secretary who collected and summarized the statistical material for me.)

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Thirty-two Nurses Study Rehabilitation Nursing

A post graduate course in rehabilitation nursing established at the Manitoba Rehabilitation Hospital in October 1963, had, by the end of March, graduated 32 nurses who comprised the first three classes.

The course covered the general principles of rehabilitative nursing, basic principles and philosophy of rehabilitation, and the medical, physical, social and psychological rehabilitation of the sick and disabled.

Formal classroom instruction and clinical experience on the wards was directed by the hospital's medical and nursing staffs and various consultants.

THE MEDICAL ASPECT IN A SHELTERED WORKSHOP

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The advantages of close and comprehensive medical supervision in the sheltered workshop are emphasized in this report based on data from observation of 35 workshop clients over a period of a year. The majority of patients were diagnosed as having cardiovascular disease, and psychiatric or emotional disorders of varying degrees of severity. Observation and supervision by a medical team composed of an internist, a physiatrist and a psychiatrist, in addition to the use of ambulatory clinics resulted in reducing potential breakdown of psychiatric patients, obviating visits to hospital clinics and reducing absences from the workshop. Integrated team work by the medical and vocational staffs resulted in a form of dynamic rehabilitation, increasing the effectiveness of the workshop in assisting the handicapped to progress toward normal living and a productive vocational status.

Effectiveness of Workshops

Various publications and reports within recent years bear striking testimony to the effectiveness of sheltered workshops in the realm of vocational rehabilitation of the handicapped. But there has been some reluctance to define or delineate sharply the services and objectives of the sheltered workshop itself. The Policy Committee of the National Rehabilitation Association of the U.S.A. accepts the following definition: "A sheltered workshop is a work-oriented rehabilitation facility with controlled working environment and industrialized vocational goals, which utilizes work experience and related services for assisting the handicapped person to progress toward normal living and a productive vocational status."

The structure of sheltered workshops was primarily designed as a service of employment for severely-disabled people. In the past few years,

the contribution of the sheltered workshop was not specifically limited to employment but included a wide variety of diagnostic, therapeutic and training services closely associated with actual work experience and with the vocational rehabilitation process itself.

The assumption of this broader function of sheltered workshops may be directly attributed to the following factors: the growth and qualitative development of rehabilitation; changing social attitudes towards disability; disabled individuals and work itself, as well as the direct result of the training, experiences and maturing attitudes of sheltered workshop personnel.

At a "European Seminar on Sheltered Employment"¹ held in The Hague, Netherlands in 1959, it was unanimously concluded that sheltered employment should be integrated into the total process and organization of rehabilitation. This requires close contact and team work with other agencies in the field of rehabilitation, particularly medical services and institutions, educational and vocational services, and social work agencies. This concept of including the workshop within the general phase of rehabilitation has played a great role in the over-all effort to assist the handicapped to help themselves. It is obvious that much additional research is required to formulate specific techniques and programs in the workshops which can deal most effectively with the different groups of the severely handicapped, e.g., those with cerebral palsy, epilepsy, the mentally retarded, etc.

Basic Functions

The basic functions of a sheltered workshop may be enumerated as follows: (a) to evaluate the disabled persons' vocational potentials; (b) to assist them in establishing vocational goals and

improve their functioning as productive workers; (c) to classify disabled persons for ultimate competitive work or for sheltered employment; (d) to refer disabled persons for vocational training not found in the sheltered workshop and for additional rehabilitation and related services; (e) to provide training programs that are not available to disabled persons elsewhere; (f) to carry on what might be termed pioneering functions in the workshop field, including research and public education.

Essential Characteristics

The essential characteristics of the sheltered workshop include the following: (1) a multi-discipline approach to evaluation, training and work preparation with emphasis on self-help and productivity; (2) a controlled environment conducive to independent work with flexibility in planning and services; (3) a dynamic atmosphere that promotes social and work integration; (4) the appropriate personnel and facilities to establish and maintain these connections through the aegis of a community-oriented approach.

Feintuch,² one of the pioneers in this field in Canada and the U.S.A., has described a sufficient number of common elements which form the basis of a conceptual framework for explaining the effectiveness of sheltered workshops in vocational rehabilitation:

1. Relief from social isolation.
2. Lifting the communication barrier.
3. The acquisition of good work habits.
4. The acquisition of confidence.
5. Effectiveness of vocational and psychological counselling.

Rudd and Feingold³ have advocated more intensive cooperation between medical and vocational services. The sheltered workshop of the Jewish Vocational Service of Montreal had been functioning without medical supervision since its inception. In keeping with the newer concepts, a medical program was introduced, embracing an over-all approach in view of the clients with chronic disease and emotional disorders. The present communication will attempt to outline the value and progress of a medical evaluation program of one year duration that was instituted in this sheltered workshop through a Provincial-Federal Grant in November, 1959.

Objective of Program

The objective of the medical program is to assist the professional staff of the Jewish Vocational Service by evaluating the physical and mental condition of each client, (a) at the time of consideration for acceptance into the workshop; (b) during his workshop employment; and (c) at the time of consideration for regular employment.

The program is under the direct supervision of a Medical Director who is the internist, assisted by a physiatrist and psychiatrist.

The Role of the Internist: The internist completes a medical evaluation of each client being considered for the workshop. Whenever possible his examination is conducted in conjunction with the psychological examination given by the Jewish Vocational Service staff. Periodic examinations of all clients in the workshop are made by the internist. He has the responsibility for ascertaining that medical treatment recommended is being followed by the clients. Where specific employment in industry is being considered for a client the physician evaluates the medical feasibility of such employment for the individual client. He maintains a continuing medical record of all workshop clients.

The Role of the Physiatrist: After acceptance into the workshop, the physiatrist evaluates the client for myodynamics, joint impairments, work tolerance and the activities of daily living. He also reviews clients from time to time at the request of the internist and workshop supervisor. Prosthetic appliances are evaluated from the viewpoint of maintenance and for modification or replacement if warranted. If there are specific indications for further physiatric procedures, the client is referred to a Department of Physical Medicine and Rehabilitation for treatment. If possible, the client continues his work on a part-time basis while receiving treatment.

The Role of the Psychiatrist:^{4, 5} The contribution of a psychiatric consultant to an industrial sheltered workshop divides itself into service and advisory-education functions. The psychiatrist's role is, to a great extent, determined by the character of the workshop and, of course, by the patients in attendance. Although the facility is mainly terminal in character, an important objective is to move into regular jobs those clients who

have the potentialities. The goal of the workshop is, in many ways, similar to that of military medicine generally, i.e., the re-establishment of function within the limits of the patient's capabilities, rather than of the long range and definite therapeutic goal. The relative numbers of patients with primary, as opposed to secondary, psychiatric disorders, are often the determining factor of the psychiatrist's role. The presence of chronic schizophrenics, or of acute schizophrenics in remission in the workshop brings with it the need for close liaison with the referring institution and almost always the additional need for on-going treatment. On occasion this is urgently required and it is here that the psychiatric consultant can achieve an economy of time and effort in dealing with the situation at hand, or at least by cutting through the usual administrative delays that present themselves.

Psychiatric disorder associated with, or secondary to, organic disease is more properly the field of the internist with the psychiatrist in a consultative capacity when indicated.

Latterly, the workshop has become interested in the habilitation of adolescents with severe character disorders. The etiology of these character disorders, is multiple, but minimal brain damage and/or low average intelligence are frequent concomitants. This group of clients requires much more in the way of counselling and supervision than does the adult workshop population, and consultation to the workshop personnel is, therefore, much more intensive. The workshop becomes a most valuable therapeutic tool in aiding these adolescents, possibly one of the most effective yet devised. The symptoms of acting out character disorder remit rapidly in the stable, adult environment that the workshop presents.

The heterogeneity of this workshop is a distinct advantage to all concerned. The advantage to the patients stems from its greater similarity to the conditions they will encounter in industry, and it is in the area of milieu therapy that the workshop provides its greatest good.

Structure of the Workshop

All clients referred to the workshop are first interviewed at the parent Vocational Service Office. They are then evaluated at the workshop by the counselling psychologist and internist, to decide whether they should be accepted.

The staff at the workshop consists of the supervisor and foreman. The supervisor, who is a graduate psychologist, embodies a dual role of: (1) An employer, whose premises must simulate a business establishment which must be conducted efficiently. (2) As supervisor and counsellor, he observes clients, utilizing professional techniques to evaluate the client's attitude, motivation, and work habits. This includes observation of ability to get along with fellow workers, ability to take supervision, ability to fit into a group setting, attendance, appearance, concentration and work organizational ability. Counselling sessions are held with the aim of helping work adjustment. Finally, he must determine work competence and adaptability. The foreman supervises the work of the clients and assists in solving any problems in the routine of the work. He reports constantly to the supervisor. When the supervisor and physician agree that the client is ready for work in the community, efforts are directed toward selective placement. Placement is based on vocational, physical and mental adjustment.

The primary objective of this workshop since its inception is to assist the handicapped and aged persons to become partially, if not entirely, self-supporting. Whenever possible, every effort is directed to help them move into industry. There are no limits placed upon the length of stay of clients in the workshop. The majority of the present clients, by virtue of age and severe handicaps, will probably not be moved into industry. For these people, the workshop serves a most useful purpose in helping them to become self-supporting and in contributing to their sense of personal worth and dignity.

Though the workshop is 10 years old, it is only within the past three years that professional staff appointments were made. On the average, 25 clients work in the shop. Virtually all are now working on a full time basis, which has been due to an effective work procurement committee.

Hours Worked and Wages Earned by Workshop Clients

Total man hours worked:			
1960	1959	1958	1957
33,994	26,676	22,330	10,296
Total wages earned:			
\$13,716	\$13,061	\$7,474	\$3,016

Plans are at present being studied to enlarge this workshop to serve 35 clients, and to initiate a pilot Work Adjustment Centre, to serve an experimental group of five clients. Included in this group will be educable, mentally retarded adolescents.

Progress

Since the medical evaluation program was instituted in November, 1959, 35 clients of the sheltered workshop were duly examined in a period of one year to November 1960. A system of medical recording was introduced, with comprehensive history of illness, social history and physical examinations patterned after teaching hospitals. Forms were especially printed for the Jewish Vocational Service. Hospital reports, where indicated, were obtained, the purpose being to establish a complete diagnosis with knowledge of medication that the client is presently taking.

Ambulatory clinics are held during the visits of the internist to examine patients with any complaints. The objective is to eliminate as much as possible unnecessary absences by the clients from the workshop. The ambulatory clinic is also utilized for first aid assistance, i.e., cuts, bruises, washing ears, etc.

Regular discussions are held with clients who have psychiatric or emotional disorders. This measure is important in detecting potential breakdown, and if indications are present, immediate referral to the hospital or clinic which the client is attending is made.

Regular conferences are held on clients with physical or emotional problems attended by the combined staff of Executive Director, supervisor of the workshop, (vocational counsellor), internist, psychiatrist and physiatrist. These conferences illustrate the constant team work between physicians and the vocational department. In addition, the visits of the internist to the workshop have afforded an opportunity for the physician and the counselling psychologist to improve understanding of each other's duties.

TABLE 1: Age

Range (Years)	No. of Clients
15-40	13
41-64	9
65-76	13
.....	—
Total	35

Discussion

There is a predominance of males in the total number of clients as compared to females, in a ratio of over 2:1.

In the age classification, the older (65 to 76) group and middle-aged group (41 to 64) form about three-fifths of the total number, and the younger group (15 to 40) constitute approximately two-fifths (Table 1).

Psychiatric and emotional comprise over half of the handicaps. Of 19 patients studied, nine had primary disorders, there being five cases of schizophrenia, three of psychoneurosis and one of depression. The remaining 10 patients had principally anxiety or depressive states associated with organic conditions. Some of these patients had been treated in mental institutions and others were currently attending psychiatric clinics of various hospitals. All of these clients were examined from time to time by the psychiatrist in the workshop.

TABLE 2: Type of Handicap

(Clients may have more than one condition)

Handicap	No. of Clients
Psychiatric and Severe Emotional Problems	19
Cardiovascular Disease	8
Arthritis	6
Epilepsy	3
Mental Retardation	3
Cerebral Arteriosclerosis	3
Hemiplegia	2
Miscellaneous:	
Colostomy (following resection of malignancy of bowel)	2
Chronic Bronchitis	2
Cerebral Palsy	1
Arrested Pulmonary Tuberculosis	1
Bell's Palsy	1
Duodenal Ulcer	2
Amputee	1
Pyelonephritis	1

Medical Aspects—Cardiovascular disease was present in about one-fifth of the patients (eight clients). This included coronary artery disease, hypertensive cardiovascular disease and peripheral vascular disease. Since these patients were receiving medication, they were carefully observed at the hospital clinic as well as in the workshop.

Six patients had osteoarthritis of the spine, knees and hands of mild to moderate degree which did not interfere very much with work activities. Three patients with epilepsy were free from seizures under medication and were examined at regular intervals at the Montreal Neurological Institute. The three clients with mental retardation were able to acclimatize themselves to different modes of work in the shop, and their performance was good. Evidence of cerebral arteriosclerosis of a mild nature was present in three cases with no untoward effects on productivity. It is of interest that two patients with hemiplegia were present in the younger age group. One young woman of 19 had a left-sided hemiparesis following meningitis in childhood, and a client nurse aged 39 had a right-sided hemiplegia following the rupture of an angioma of a vessel in the left fronto-temporal region, which necessitated a craniotomy 10 years ago (Table 2).

The geriatric age group included 13 patients from 65 to 76 years of age, 11 men and two women, who have been employed at the shop for periods ranging from five months to nearly five years. Their earnings compare most favorably with the younger clients, and three members of this group are among the highest earners in the workshop. As a group, they are highly motivated and well preserved, despite certain infirmities of age. They have demonstrated work judgment, adaptability to work routines and pressures, and the ability to perform various jobs. If not for the age barrier, several clients in this group could be placed in industry.

There has been a decrease in unnecessary absences from the workshop as a result of ambulatory clinics and regular medical supervision. Several psychiatric patients with impending breakdown were noted and treatment immediately instituted.

Summary of Case Histories of Clients Placed in Industry

Five clients were placed in industry. It is to be emphasized that a guarded prognosis must be given as to how long these clients may function in industry, without any setbacks.

Case No. 1: Miss S. S., aged 21, was referred by the Jewish General Hospital because of a depression state, mental retardation and epilepsy, although the latter was under medical control.

Despite initial temper tantrums, her work behavior gradually improved. She was taught how to operate a tape winding machine and a power sewing machine. After one year in the workshop, she was placed as a sewing machine trainee in a clothing factory, where she has been working for the past five months. The supervisor received a very satisfactory report from the employer, and was pleased to see the client operating a sewing machine in a skilled and rapid manner.

Case No. 2: Mr. M. C. aged 40, was referred by the Verdun Protestant Hospital. He had been hospitalized for schizophrenia several times, his most recent hospitalization lasting nine years. At first he was unsure of himself, seemed out of contact with the work situation, and was unable to relate to other workers or to the supervisory staff. As time progressed, he slowly became more confident and more in touch with the work environment. With reassurance and praise, which were of great benefit to him, his work production increased considerably. In recognition of his improved performance, he was given more complex jobs which he did adequately. From this point on, his performance underwent dramatic change. He became one of the best producers in the workshop. After four months, he was placed in a clothing factory where he has been working for the past eight months. The latest report indicated that his work was satisfactory, and that he was regarded as a permanent employee.

Case No. 3: Mr. H. J., aged 21, was referred by the Employment Department of the Agency. Previously, he had been dismissed from several jobs after brief periods of employment because he had made errors, had been very slow and careless in his work, and had been impudent to his superiors. He had been at one time arrested by the police for molesting a young girl. He started psychiatric treatment which was discontinued after a time. (Diagnosis: Psychoneurosis with behavior problem.) He exhibited attitudes of hopelessness about himself and hostility toward the world.

Initially, counselling with him was concentrated on developing a strong relationship with the supervisor. His early performance at the workshop was similar to the way in which he had worked in industry. He was not discharged for

his poor work behavior as in industry, but was made conscious of that point by the supervisor. Gradually he began to recognize how his actions were related to his past failures, and slowly, with this type of supervision, his work performance improved. After eight months, his work became consistently better. He was placed as a warehouse assistant in a clothing manufacturing firm, where he has been working for the past three months. The most recent contact with the employer indicated that he was working satisfactorily.

Case No. 4: Mr. D. S., aged 37, was referred by the Verdun Protestant Hospital. He had been hospitalized for schizophrenia on several occasions since 1945, the most recent admission lasting for two years. At the time of referral to the workshop, he had been out of the hospital and unemployed for 18 months. During the initial period he worked slowly and did not seem interested in the work situation. While he learned jobs easily enough, he apparently did not understand what was expected of him as a worker in terms of his personal behavior. The psychiatric consultant felt that he had good potentialities for rehabilitation, since he did not present active psychotic symptoms. The supervisory staff placed him on jobs where he could work jointly with other workers. He was pushed by these other workers to work more quickly and as a result his earnings increased. For the first time, he had the opportunity to note how greater work effort resulted in greater monetary reward. He began to work more rapidly and evinced a greater interest in the work situation. After nine months in the workshop, his work performance improved to the point where he could be placed in industry. He has been working as an assembler and shipper for the past two months in a satisfactory manner according to the employer.

Case No. 5: Mr. M. O., aged 46, was referred by the Psychiatry Department of the Jewish General Hospital. There was a long history of depression for over eight years, for which he was hospitalized on several occasions and received shock treatment and drug therapy. He was found to be a dependent person, and it was felt that he could be helped toward rehabilitation in the workshop by a process of increasing responsibility through various jobs.

The psychiatric consultant found him to be moderately depressed with excellent ego resources and a minimum of psychotic defenses. He recommended combined drug and psychotherapy at the hospital. (Patient had previously discontinued treatment at other hospitals.)

The client had difficulty in accepting work changes and supervision, and complained of depression. He functioned quite well on various and complex job operations.

In October 1960, (after 27 months in the workshop) during a period of slow employment in the shop, he voluntarily left the workshop and obtained a job as a salesman. After seven months, he was still working.

Six clients left the workshop in this period for varying reasons such as inability to adjust to marital and medical problems.

Summary

1. The basic concept of integrating sheltered employment into the total process of rehabilitation requires integration with other agencies in the field of rehabilitation, particularly medical services and institutions, educational and vocational services, and the social service work agencies.
2. The organization of a medical program instituted through a Provincial-Federal Grant in conjunction with the Jewish Vocational Service in a sheltered workshop in Montreal is outlined. Evaluation of the program after a one year period is described.
3. Through the medium of ambulatory clinic interviews and conferences, an excellent rapport has been established between the individual clients and physicians. This has resulted in reducing unnecessary absences from the workshop as well as obviating visits to hospital clinics. Potential breakdown of psychiatric patients has been discovered, and treatment has been immediately instituted.
4. Thirty-five clients were duly examined during this interim. Psychiatric and emotional disorders and cardiovascular disease comprised the great majority of the handicaps. Five clients with psychiatric involvement including one epileptic were placed in industry. Six clients left the workshop for varying reasons.

5. The medical program has afforded an opportunity for the medical and vocational staff to improve understanding of each other's work. The integrated teamwork activities of the medical and vocational staffs have resulted in a form of dynamic rehabilitation.
6. The sheltered workshop develops considerable motivation by work conditioning and by stressing the changing of attitudes and the learning of skills. These factors are enhanced through regular medical supervision.
7. The milieu of the workshop is thus conducive for the handicapped and aged to adjust

to work, with the possibility of being subsequently placed in industry.

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VOCATIONAL REHABILITATION OF OLDER DISABLED PERSONS

(Little-known feature of Canada's federal-provincial program of vocational rehabilitation services for disabled persons is that it has no upper age limit. Of 1,814 cases of successful rehabilitation in 1962-63, more than 400 were aged 45 or over).

Canada's federal-provincial program of vocational rehabilitation services for disabled persons is fairly well-known. What is not so well-known is that the program has no upper age limits. Many persons of advanced age have been and are being successfully rehabilitated, many to suitable employment.

It is widely accepted that age in itself can be a significant social handicap to obtaining or returning to gainful employment. When this handicap is coupled with a physical disability the odds against a return to self-sustaining status are multiplied.

In view of those difficulties, success in even a relatively small number of cases is significant and offers ample evidence that older, and sometimes quite elderly disabled persons can become self-sustaining. If it can be done for those with disabilities what might be accomplished for those who are able-bodied and in good health?

Of 1,814 cases of successful rehabilitation reported in 1962-63, 407 or 22.7 per cent were aged 45 or over. Of this number, 267 were men and 140 were women. Eighty-four of these older people, 46 men and 38 women, were in the age group 66 and over; 121, of whom 82 were men

and 39 women, were in the 56-65 age group; the remaining 202—139 men and 63 women—were aged from 45 to 55 (see table, Part A).

These older people suffered from various types of disabilities in the following classifications: amputations, neuro-muscular-skeletal, hearing, seeing, neurological, respiratory, cardio-vascular and neuro-psychiatric problems (see table).

Despite these disabilities and their advanced ages, 227 of them—184 men and 43 women—were rehabilitated into gainful employment and the remainder were enabled to look after their own needs or to assume their normal roles as housewives (see table, Part B).

The types of occupations entered by these 227 disabled older people is significant also. Nine men and two women entered the professional and managerial field; 40 men and 11 women became sales persons or clerical personnel; 37 men and 26 women were placed in service occupations; 22 men went into agriculture, fishery or forestry occupations; 30 men and 1 woman became skilled workers; 12 men and 1 woman became semi-skilled workers; and 34 men and 2 women were placed in unskilled occupations.

Part 3 of the table indicates that rehabilitation

DISABLED PERSONS 45 YEARS AND OVER, 1962-63

A—Disabilities

Age Groups	Amputations		Neuro-Muscular Skeletal		Hearing		Seeing		Neuro-logical		Respira-tory		Cardio-Vascular		Neuro Psychiatric		Misc		Total		Total
	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	
45-55.....	15	4	40	21	15	9	15	2	9	10	19	5	11	4	8	8	7	.....	139	63	202
56-65.....	12	2	25	15	10	5	9	4	15	9	7	1	3	1	1	1	.....	1	82	39	121
66 and over.....	22	7	10	14	1	3	8	7	5	6	.....	.....	.....	.....	.....	.....	1	46	38	84	
Total.....	49	13	75	50	26	17	32	13	29	25	26	6	14	5	9	9	7	2	267	140	407

B—Occupations after Rehabilitation

Professional and Managerial.....	1	.....	2	1	2	.....	.....	.....	1	.....	1	1	.....	.....	1	.....	1	.....	9	2	11
Sales and Clerical.....	6	.....	11	2	1	2	9	.....	2	1	6	1	3	1	2	4	.....	.....	40	11	51
Service Occupations.....	5	.....	8	6	11	8	2	3	1	1	5	3	2	1	3	3	.....	1	37	26	63
Agriculture, Fishery, Forestry, etc.....	3	.....	11	.....	1	.....	2	.....	.....	.....	2	.....	.....	.....	1	.....	2	.....	22	.....	22
Skilled Occupations.....	5	.....	10	.....	2	.....	3	.....	1	.....	3	.....	4	.....	.....	1	2	.....	30	1	31
Semi-Skilled Occupations.....	2	.....	2	.....	1	1	.....	.....	2	.....	3	.....	2	.....	.....	.....	.....	.....	12	1	13
Unskilled Occupations.....	5	.....	15	.....	7	2	3	.....	.....	.....	4	.....	.....	.....	.....	.....	.....	.....	34	2	36
Housewife or Homemaker.....	.....	6	.....	23	.....	3	1	7	.....	10	.....	1	.....	2	.....	.....	.....	1	1	53	54
Self Care.....	21	7	14	17	1	1	4	1	22	13	2	.....	1	1	1	1	2	.....	68	41	109
Part-time Employment.....	1	.....	2	1	.....	.....	8	2	.....	.....	.....	.....	2	.....	1	.....	.....	.....	14	3	17
Total.....	49	13	75	50	26	17	32	13	29	25	26	6	14	5	9	9	7	2	267	140	407

C—Duration of Services

Under 6 months.....	14	3	19	19	14	12	10	6	11	8	7	3	4	3	3	2	3	2	85	58	143
6 to 12 months.....	15	5	22	16	10	5	11	2	4	7	5	.....	2	.....	3	2	1	.....	73	37	110
12 to 24 months.....	10	3	10	10	1	.....	6	1	13	7	5	3	4	2	2	4	2	.....	53	30	83
Over 24 months.....	10	2	24	5	1	.....	5	4	1	3	9	.....	4	.....	1	1	1	.....	56	15	71
Total.....	49	13	75	50	26	17	32	13	29	25	26	6	14	5	9	9	7	2	267	140	407

services take time. For 71 of these older disabled persons more than 24 months were required; but for 143 less than six months were needed.

The numbers involved were relatively few but still represented a significant proportion (22.7%) of all cases reported to Civilian Rehabilitation, Department of Labour, in 1962-63.

The following case histories are typical.

Case 1—Mr. X, aged 63, with a Grade 9 to 10 education, had had arteriosclerotic gangrene necessitating above-knee amputation of the right leg. His previous occupation had been tool-maker. His rehabilitation services, which lasted nine months, included surgery, physiotherapy, occupational therapy and an artificial limb. He was enabled to return to tool and die making, earning \$347 monthly.

Case 2—Mr. Y, aged 65, had educational

qualifications ranging from the equivalent of Grades 5 to 8. His disability was intervertebral disc deterioration in the lumbar region. He suffered back pains and had difficulty in walking. The disability began in 1958. He had been a labourer, but was on public assistance at acceptance for rehabilitation services. After eight months of medical treatment and physiotherapy he was placed in unskilled labour at \$300 monthly.

Case 3—Mr. A, aged 71, has education equivalents Grades 5 to 8. His disability was vascular deficiency, necessitating amputation of the left leg below the knee. On Old Age Security he was formerly a labourer. Rehabilitation services took eight months and included surgery, provision of an artificial limb and counselling after which he became self-employed at odd jobs.

supplementing his old age pension by about \$25 monthly.

Case 4—Mr. Z, aged 58, has Grades 5 to 8 educational standards. His disability was pulmonary tuberculosis and he had to be confined to light work only. He had once been a barber. After seven months of rehabilitation services, including medical and psychological services,

physiotherapy, occupational therapy and counseling, refresher training and provision of barbering tools, he was able to resume barbering and earn \$180 a month.

The foregoing are just a few examples from among many, but they do indicate some of the possibilities for vocational rehabilitation among older persons.

HANDICAPPED PERSONS BUSINESS FLOURISHES

(Written by DONNA LOGAN of the *Halifax Chronicle-Herald* for their issue of December 28, 1963 and reprinted with permission of the publisher).

Ten years ago two Montreal war veterans, tired of big city life, decided to settle in Nova Scotia. They chose a picturesque spot about 14 miles outside Liverpool known as Port Joli.

Their decision was to have far-reaching effects on the province's handicapped and resulted in considerable saving for the Nova Scotia government.

The two men, Charles Kelsey and George Whalley, had been paraplegics since World War I but they had no intention of sitting idly by the fireplace in their wheelchairs feeling sorry for themselves.

Instead they embarked on an ambitious business venture requiring full-time attention and more-than-ordinary stamina. The business, a book binding shop, opened a year ago in an inconspicuous-looking building next to a lumber yard in Liverpool.

A clearly printed sign on the front of the building read "K and W Enterprises Ltd". Three persons, all handicapped, were employed and the operation was launched with little or no notice.

Before the shop opened Kelsey and Whalley had approached the Nova Scotia Department of Education for a concession to repair school texts which, up to that point, had been thrown out. The province agreed and they were in business.

Although repair and binding of school texts still constitutes the bulk of work done by the shop, their services are being used by an increasing number of private concerns.

Operation Expands

With 10 percent of the 900,000 books in use in Nova Scotia schools requiring repairs every

two years, the operation soon expanded. By mid-August the payroll in the Liverpool shop included a dozen persons and a branch had been opened in New Glasgow employing another 12 handicapped workers.

Now the two shops employ a total of 23 persons and further increases are anticipated. In fact, if present plans materialize, the operation may someday provide employment for a great many handicapped persons in Canada. Kelsey and Whalley hope to expand to New Brunswick next year and have made inquiries in other areas.

The Nova Scotia government naturally welcomes the establishment since it has resulted in considerable saving for them. Officials of the Department of Education estimate that rebinding prolongs the life of each textbook at least two years.

With normal use, a hard-cover book will last for three or four years and the cost of rebinding is considerably less than replacement. Both department officials and school inspectors are extremely pleased with the work being done by "K and W Enterprises".

Neither Kelsey nor Whalley regard the undertaking as particularly unusual or noteworthy. In fact, they seem not to be consciously aware of the fact that either they or the people they employ are different from anyone else. They look on the shop as a straight business venture—nothing more, nothing less.

"This is no welfare organization", says Whalley, a heavy-set jovial man. "We treat our employees like anyone else and we expect the same kind of treatment".



Mr. Whalley, left, and Mr. Kelsey check one of the many orders they are now handling in their book-binding operation.

Two-Week Trial

There are no concessions and if an employee doesn't measure up, he is fired. Each person is placed on a two-week probation period at the beginning of employment and if, at the end of that time, both employee and employer are satisfied, the person stays.

The two-week trial period is essential because many of the people have never had an opportunity to work before and are unable to assess their own limitations. The work is not suitable for severely disabled persons but the payroll includes a number of paraplegics, arthritics, retarded, polios, amputees, arrested TB etc. who range in age from 19 to 57.

The staff works a full eight-hour day which originally began at 8 a.m. and ended at 5 p.m. with an hour for lunch. At the request of the employees, the lunch hour was shortened to half an hour and work now stops at 4:30 p.m.

The starting wage is 75 cents an hour with a raise of 10 cents an hour at the end of three months and a bonus arrangement based on total shop production. In offering these wages, Kelsey and Whalley realized the wage was small but as the business becomes established it is their personal feeling and desire to share their profits with employees thus bringing the wage level up to good living standards.

Many of the employees were receiving disability pensions before they began working and these were cancelled once the person earned more than the specified amount.

Whalley thinks this unfair and that it discourages many handicapped people from leading useful, productive lives. He and his partner have joined the ranks of many other individuals and organizations protesting this practice.

"After all" says Whalley, "war pensioners like ourselves are not cut off when we begin earning".

Being handicapped themselves, Kelsey and Whalley are well qualified to deal with the people they employ. Prior to coming to Nova Scotia, the pair had several years experience in Montreal operating a pre-vocational training school for the handicapped—a project originally started by Kelsey.

It ceased operation in 1952 but by that time, both men had gathered valuable experience in training people. In a sense, their shops in Liverpool and New Glasgow are training centres since it is their aim to train workers as qualified book binders who can compete for employment in any firm of this type.

When a branch was opened in New Glasgow on June 17, it was one of the first workers trained at the Liverpool shop who was placed in charge as foreman.

The production figures at "K and W Enterprises" indicate that the workers have a good chance to step into the competitive market. At present, the workers compete among themselves with the Liverpool crew keeping a close eye on production in New Glasgow and vice versa.

At Liverpool, the workers process an average of 204 books a day with each individual averaging 20 books a day. The staff works in pairs and instead of an assembly-line operation, the team stays with the book from beginning to end.

The results of their work are impressive. Some of the books piled along the wall ready for re-binding appear well beyond the stage of repair. While a small percentage does have to be discarded, the salvagable pages are saved to replace missing pages in another book.

A bright new binding gives the appearance of a new volume, but does not conceal "a multitude of sins." After the K and W team has been through a book, it has been cleaned and missing pages replaced.

Employment of these people does a great deal more than just provide them with a job, say Kelsey and Whalley. It helps them discover themselves and to establish an identity and personality. They enjoy their work and the result is a happy shop.

Both partners derive a great deal of satisfaction from their bold venture. The Kelsey-Whalley partnership began in a hospital in Ste. Anne de Bellevue, Quebec, where both spent several months recuperating from war efforts in Italy and France.

Kelsey, who was born in London, England and settled in Montreal, and Whalley, a native of St. Jean, Quebec, became good friends and then business partners.

THE ATKINSON FOUNDATION HELPS IN REHABILITATION

The Atkinson Charitable Foundation was set up by Joseph E. Atkinson in 1942 to receive and maintain a fund and apply the income for religious, charitable and educational purposes within the province of Ontario. Since then many services and institutions have been established or enabled to expand services through grants from this fund. Some of these have been of special interest to persons concerned with the care and training of disabled persons. The Audiology and Training Unit for Infants and Young Children at the Hospital for Sick Children is an example. This service was established in 1963 with a grant of \$15,000. Early in 1964 a further grant in excess of \$6,000 was received which will enable the clinic to continue its work through 1964. The following news report indicates the service being provided at this centre.

Help for Deaf Children

"The seven-month-old infant's eyes lit up and a little smile appeared.

"It was a contagious smile. It erased the lines of worry from the face of the mother. And even the doctor and the teacher at the Audiology and Training Unit for Infants and Young Children at the Hospital for Sick Children smiled anew at the familiar reaction of a hard of hearing child entering for the first time the world of sound.

"Susan's mother had noticed her baby was not reacting to sound like her other children had. A wise mother, she took her child to the unusual clinic. Susan's mother soon learned that young children do not mind needed hearing aids that bring them the wonderful sounds of the world around them.

"If children begin to wear hearing aids young enough they get to love them. Some actually cry when we try to remove them' said Louise Crawford, the experienced teacher at the clinic. Miss Crawford obtained her Bachelor of Arts degree from Smith College, and was trained at the Clarke School for the Deaf in the United States. She taught there and in England before coming to Toronto.

"Three-year-old Andria was once diagnosed as totally deaf, but through a hearing aid and careful training at the clinic and at home she is now beginning to say her first words. 'I don't like the term totally deaf,' said Miss Crawford. 'Most children have some residual hearing although they might not appear to'.

"While heredity is a factor and some can be traced to such diseases as German measles during for mother's pregnancy, Miss Crawford said the cause is not known in about 30 per cent of hard of hearing cases.

"The purpose of the Hospital for Sick Children's program is to show parents how to train their hard of hearing children at home. When possible, the teacher works with the child from the time hearing loss is diagnosed until the child is enrolled in a special school or regular kindergarten.

"In its first eight and a half months of operation, the clinic provided about 600 lessons to 43 children. It has also interested students and nurses from the University of Toronto's speech pathology and audiology course. To facilitate this teaching work, a one-way window and microphone attachment are to be installed in a room adjoining the clinic."

Further Grants Announced

Announcements of new grants are made from time to time. Among recent grants the following are of particular significance to rehabilitation workers:

Truck to Aid Disabled

The Foundation recently announced a grant of \$8,048 to the Amity Rehabilitation Centre in Hamilton, Ontario, for the purchase of two trucks to be used in its collections of used clothing and furniture for processing in its workshop.

The program includes training in furniture refinishing and upholstery, shoe repairs, cabinet repairs, sewing, cleaning and pressing.

Last year the Amity Centre took nearly 1,000 contracts for re-upholstering and refinishing furniture from industries, hospitals and private citizens.

Collection boxes placed at 40 shopping centres in the area have led to a doubling of donations of used clothing. Gordon Mann, executive director of the Centre says, "The trucks are a godsend to us. The collection boxes are our main source of supply. We could keep a truck going all day, every day, doing nothing but picking up donations".

The Centre employs a full-time staff of 54 disabled persons and at present has 22 trainees taking job-training.

Bus to Transport Children

A grant of \$5,345 to the North Waterloo Society for Crippled Children will enable the Society to purchase a bus to transport children to and from the Society's treatment centre. The grant will also cover the cost of special hydrotherapy equipment for the Centre's new pool, some general items for the nursery school and some physical therapy equipment.

Bursaries for Nurses

Four thousand dollars granted to the Victorian Order of Nurses will provide bursaries in Ontario nursing schools for nurses joining the VON to take post graduate training in public health nursing.

Help for Visually Handicapped Children

The Strothers Exceptional Child Foundation Inc., Toronto will supervise an experimental project

to provide condensed large-type school texts for visually handicapped children. A grant of \$3,000 from the Foundation will finance the project. This project was begun five years ago by Mrs. Jean E. Moody, of Hagley Road, Scarborough when she first prepared a Grade 7 text for her daughter. Volunteer help has helped her put out condensed magnatype versions of 17 texts and other books.

Teachers have found these valuable for partially sighted students enabling them to keep up with their classmates. Requests for copies have come from teachers in a number of cities. This grant will permit hiring of part-time help to do typing and to have the books reproduced on a copying machine.

Camping for Mental Patients

Another grant of \$20,000 from the Foundation to the Metro Toronto branch of the Canadian Mental Health Association will be used to set up, over the next three years, a 10-day camping holiday for 100 patients from the Ontario Hospital in Toronto annually at an attractive site on Lake Ontario near Niagara-on-the-Lake. The camp facilities were erected and operated for 20 years by the Tubercular Veterans' Camp. But with new drug treatment cutting down tuberculosis, the need for the camp disappeared. This spring it was turned over for charitable purposes and rented to the Canadian Mental Health Association for a nominal \$1 a year charge.

People and Events

Mountain Sanatorium, Hamilton, Ontario Adapts to New Needs

When early diagnosis campaigns and the discovery of effective drugs reduced the time in hospital required by persons with tuberculosis to an average of about six months, the Hamilton Health Association started a conversion program to meet pressing community needs. The first result was the establishment of the Chedoke General and Children's Hospital.

This year further changes have taken place and the third and fourth floors of the remodelled Evel building have been allotted to a rehabilitation program.

Dr. John B. Neilson, MBE, Chairman of the Ontario Hospital Commission, who opened the newly renovated hospital, emphasized the need for such rehabilitation centres. He felt they were required to meet the needs of a growing number of patients who need rehabilitation rather than long-term hospital care.

Nurses Receive Training in Rehabilitation

The Sanatorium Board of Manitoba has established another new teaching program at the Manitoba Rehabilitation Hospital. Ten student public health nurses from the University of Manitoba attend the hospital once weekly for field practice and experience in the specialty of rehabilitation.

Maj. Gen. Melvin J. Maas Dies

Rehabilitation workers in Canada will join with those in the United States to mourn the death on April 13 of Major General Melvin J. Maas, USMCR Ret., 65, Chairman of the President's Committee on Employment of the Handicapped, a position he has held since 1954. Under his leadership, the President's Committee not only intensified its educational and promotional efforts on behalf of the physically handicapped, but also expanded its functions to include the mentally handicapped.

A highly decorated veteran of three wars, General Maas was blinded in 1951 as a result of an injury received in World War II. Nevertheless, as chairman of the Presidents' Committee, he has travelled widely urging equal opportunities for the handicapped and has made a host of friends both in his own country and in international circles who will be saddened by word of his death.

New Course in Welfare Services

To help meet the need for welfare workers a new course, to begin in September, 1964, has been announced by Ryerson Polytechnical Institute.

This course was proposed by the Advisory Council on Public Welfare Training to the Minister of Welfare of Ontario. It is being offered by the Ryerson Polytechnical Institute with approval of the Ontario Minister of Education. Graduates will have a general background of education and experience which will prepare them for employment in every kind of welfare agency—agencies rendering services to the aged, to families, children, juvenile and adult offenders, the handicapped and those in need of vocational counselling.

Students will study background subjects in the humanities and social sciences as well as subjects directly related to social work. The academic work will be carefully correlated with observation, work and instruction in the welfare agencies.

Admission Requirements

Applicants for admission must have successfully completed the requirements for the Ontario Secondary School Graduation Diploma, with an over-all average of at least 60 per cent in English and History of Grade XII and two of Mathe-

matics, Sciences and Languages of Grades XI and XII. Applicants must also be 18 years old by June 1, 1964. Preference will be given, however, to those who are over 20 and have had two or more years of actual work experience in any field. Those applying should have a genuine concern for people and an understanding of and sensitivity to human problems. In 1964, only one select group of approximately 25 people will be accepted.

Fees

Fees for the Academic Year 1964-65 are as follows:

General Fee	\$242.00
Students Administrative Council....	3.00
Athletic Directorate	7.00
	<hr/>
	\$252.00

Veteran Takes Training

A Greek veteran, Georges Zacharakis, was among the pupils who started the new school year last fall at the French National School of Watchmaking at Besançon.

A double leg-amputee, Mr. Zacharakis, has a one year study fellowship from the International Labour Organization and is training to become an instructor in watch-repairing at the Institute for Research and Development of Vocational Rehabilitation of the Disabled (K.A.P.A.P.S.) in Athens.

In 1960 the Institute, which conducts classes in shoemaking, tailoring, orthopedics, mechanics, carpentry, dress-making and watch-making, benefited from the services of Jean Pierrot, instructor at the Besançon School, who spent some nine months there on a joint World Veterans Federation ILO Fellowship. During this time a new watch repair workshop was installed, equipment provided by the ILO and the vocational and pedagogic training of instructors undertaken. The idea that Zacharakis should train as Mr. Pierrot's counter-part was also born, and the Greek veteran set to work to learn French.

In the first days of October, Mr. Zacharakis arrived at Geneva airport, and was driven to Besançon where he will stay in the home of Jean Pierrot during his year in France. The French Ministry of Veterans Affairs has loaned him a wheel-chair so that he can get around easily.

inside the technical college, and Mr. Zacharakis who hopes to visit France before his return to Athens, has brought with him his motorized invalid's tricycle.

Dr. Fahrni Honoured

Dr. Brock M. Fahrni, Director of the School of Rehabilitation Medicine of the University of British Columbia, and a member of the National Advisory Council on the Rehabilitation of the Disabled, has been named a Fellow of the American College of Physicians.

Wallace Graham Memorial Collection Established

The Academy of Medicine of Toronto and the Canadian Arthritis and Rheumatism Society have agreed to the establishment of a co-operative memorial to the late Dr. Wallace Graham. The memorial is to take the form of a special collection of rheumatological literature within the academy's existing library.

The collection will be designated by an appropriate plaque and graced by a bronze bust of Dr. Graham; its books will be identified by a suitable flyleaf stamp. Acknowledgement of Dr. Graham's interest in the Society and of the collaboration of this Society with the Academy in the establishment and maintenance of this collection is indicated on the plaque which was unveiled at the Academy, April 7 by Dr. Claude T. Bissell, President of the University of Toronto.

It is expected that the collection will be ultimately housed in a separate room in the Academy's proposed new library. The Academy, of which Dr. Graham was president at the time of his death, received substantial gifts in his memory. It is understood that these will be used for the purpose.

For its part the Society will support this collection by applying to it the gifts it received in memory of Dr. Wallace Graham, an amount totalling close to \$6,000. These funds will be used primarily for the purchase of new books and journals for the collection. Such acquisitions may be in any current or historical field related to the basic, clinical or sociological aspects of rheumatology.

To give advice on all matters pertaining to the Wallace Graham Collection and, particularly,

to recommend new acquisitions for the collection, the Academy has appointed and will maintain a special committee which will include at least one rheumatologist associated with C.A.R.S.

The Academy will maintain a catalogue of the collection which will be available to other Canadian medical libraries and will be prepared to fill requests for use of the collection by doctors in other parts of Canada, particularly for rheumatologists, post-graduate students of rheumatology, and all C.A.R.S. fellows.

The collection will grow steadily, and will become a unique contribution to the archives and knowledge of rheumatology. It is a memorial peculiarly fitting to Wallace Graham, bibliophile, clinician and teacher.

(From Carscope, April 1964)

New Rehabilitation Centre Opens

The new Toronto Rehabilitation Centre on Rumsey Road, which opened recently, completes a group of rehabilitation establishments planned to serve the disabled of all ages. Other units include Sunnybrook Hospital, the Canadian National Institute for the Blind, the Ontario Crippled Children's Centre and, not far away, Sunnyview School for crippled children.

This new centre replaces the former quarters of the Toronto Association of Occupational Therapy at 331 Bloor Street West and incorporates every modern feature. The centre provides occupational therapy, physical therapy, speech therapy, social services and pre-vocational assessment. Services are also made available to patients in their own homes when they are unable to be brought to the centre.

O.A.R.C. Appoints Co-ordinator of Adult Services

The Ontario Association for Retarded Children has engaged William C. Berendsen, as Co-ordinator of Adult Services. His duties will include guidance to local associations in planning, establishment and continued development of adult services including sheltered workshops, activity programs and other services required to support the adult retarded in the community. He will advise on types of programs, ways of financing, methods of operation and assistance in obtaining support and co-operation from business and industry in the area.

Employee's Good Work Highlights Efficiency of Handicapped Workers

Rosaire Dufault, stricken with polio in his early teens and now confined to a wheel chair, is the first handicapped employee that Allied Farm Equipment, Ltd., has taken on its staff. Through efforts of a placement officer of the Society for Crippled Children and Adults of Manitoba, Rosaire secured a job with the firm as telex operator and stock record clerk in January of last year.

During his year of service Rosaire has had two raises and the management is so pleased with his work that four more handicapped persons, one as assistant for Rosaire, have been added to the staff.

Other handicapped workers serving efficiently with the firm include a clerk-typist. A young man whose duties comprise those of an inventory clerk is with the associate firm of Alco Equipment, Ltd.

E. V. Paskewitz, general manager of the Winnipeg firm, has written to head office to commend the services of handicapped members of the staff and now the company as a whole is considering the practicability of employing handicapped men and women.

"He is very efficient," Mr. Paskewitz says of Rosaire. "We had an unusually busy summer in 1963 and he worked early and late. Rosaire is cheerful and obliging, is well liked by his fellow workers."

Rosaire was born in St. Front, Sask., and following the attack of polio he came under the ministrations of the Society for Crippled Children and Adults in Saskatoon.

Three years ago Rosaire came to Winnipeg. Second year of his residence here he was placed in the Society's Workshop for the Handicapped where he remained until he secured his present position. In the Workshop he received training in various phases of office routine and was given an opportunity to further practice his typing and increase his speed.

Workshop manager, Mrs. Nan Murphy, says of Rosaire, "He wanted to learn and he wanted to work. He was most co-operative, was regular in attendance, did any extra work cheerfully. He was always ready to help his fellowmen. They liked and respected him."

Rosaire is on his own now, busy with work he enjoys, living a happy and productive life. He boards at the home of his brother and sister-in-law, Mr. and Mrs. Emile Dufault, St. Vital. Last spring Rosaire bought a car, specially fitted for him to operate, and now drives to and from work. (From "The Society Page" Jan. 15/64—*The Society for Crippled Children and Adults of Manitoba.*)

N.Y. Lighthouse Prints Braille Guide to Fair

Blind persons who go to the New York World's Fair will have a specially prepared 21-page Braille pamphlet as an easy guide, made available to them by the Lighthouse, the New York Association for the Blind.

The pamphlet, called "The New York World's Fair," was written by Mae Cassidy of the Lighthouse staff and published by the Lighthouse Braille Press and Transcribing Service.

The Unisphere, the 1964 Fair's symbol, is embossed on the pamphlet's orange and blue cover. The descriptive Braille pamphlet will be free to all blind visitors at the Fair.

The guides will be distributed on request at the Boy Scout encampment at the Fair.

Dr. Ian William Davidson

The Ontario Crippled Children's Treatment Centre in Toronto suffered a grievous loss in the death of its first Medical Director, Dr. Ian William Davidson, in June. In the short time that the centre has been in operation under his direction, he and his staff had established an enviable reputation for the care and treatment of crippled children.

Dr. Davidson graduated in medicine from Toronto University in 1934 and, in ensuing years, took post-graduate training in general surgery and orthopaedic surgery in Canada and the British Isles. He was a Fellow of the American College of Surgeons, the Royal College of Surgeons of Edinburgh and the Royal College of Surgeons of Canada. For many years he was Chief of Surgery of the Sudbury General Hospital and more recently, following a heart condition, he gave up his surgical practice and accepted an appointment as the first Medical Director of the Ontario Crippled Children's Treatment Centre in Toronto.

Dr. Davidson brought to this new position a wealth of experience in the treatment of crippled children and it would be hard to find one more ideally suited to the exacting demands of the position. He had a natural and friendly manner with his patients and his professional associates and his passing will be mourned not only by his friends at the Ontario Crippled Children's Treatment Centre but by his wide circle of friends throughout Canada and other countries.

New Appointments to National Office Staff

Civilian Rehabilitation has welcomed three new members to its staff in recent weeks.

Michael E. McCormick has been appointed Assistant to the Chief of the Older Worker Division and took up his duties on May 1. Mr. McCormick, who was born in Sydney, Nova Scotia, received his education at Sydney Academy and St. Francis Xavier Junior College. He has had 22 years of service with the Unemployment Insurance Commission at the local, regional and head office levels. Following a period with UIC in Sydney, he was employment supervisor in the Cape Breton area for 12 years. In 1958 he became employment specialist at the Moncton regional office where he was responsible for promoting the use of the National Employment Service by manufacturing and construction industries. In 1961 Mr. McCormick joined the inspection staff of the Head Office and in this capacity inspected local offices of the Commission in all regions of Canada. He has a thorough knowledge of UIC operations in employment insurance and administration and had developed contacts with government bodies, organized labour, employer associations and voluntary agencies.

With his record of public service Mr. McCormick's wide knowledge and deep interest in social problems should find full scope in the expanding Older Worker Program.

Mr. McCormick has been an ardent sportsman, interested particularly in basketball, football and hockey and was instrumental in introducing Little League sports programs in his native Cape Breton. He is married and has two sons and a daughter.

Francis Patrick Ogilvie Leask, the second new member to join the staff, took up his duties, also in the Older Worker Division, on June 1. Mr.

Leask, who was born in England and received his early education there, graduated from Royal Military College, Kingston, in 1939. He was immediately assigned to overseas duty and saw service with the Canadian Army in England and Italy until 1945 when he was returned to Canada. In 1951 he was posted for duty in Korea. He retired from the army in 1955 with the rank of major.

Joining the Annuities Branch of the Department of Labour, he was transferred to the Collective Bargaining Surveys Section of the Economics and Research Branch and continued in this work until assuming his new position.

Mr. Leask is married and has five young children.

Miss Jean Dorgan joined the staff of Civilian Rehabilitation where she will be engaged in senior supervisory duties. Miss Dorgan comes from the Department of National Health and Welfare where she has been social work consultant to the Mental Health Branch.

Miss Dorgan holds a Bachelor of Applied Science (in nursing and public health) from the University of British Columbia and a Master of Social Work degree from the University of Toronto. She was first employed in the medical division of the Municipal Social Service Department and later as a Public Health nurse in Vancouver. During the war she saw service with a mobile surgical unit of the RCAMC in England, Italy and Holland. On returning to Canada, she pursued studies in social work at the School of Social Work in Toronto and has since held positions as psychiatric and medical social worker at Shaughnessey Hospital in Vancouver and as a field work instructor for the School of Social Work in Toronto. She also managed to work in a period at Letchworth Village, a hospital school for the retarded in New York State.

Among her duties in the Mental Health Division was that of advising upon the use of the Mental Health Grant in the development and improvement of social and vocational aspects of rehabilitation. A particular responsibility has been keeping abreast of developments in services for the mentally retarded in Canada and elsewhere. For the past three years she has been a member of the Scientific Research Advisory Board of the Canadian Association for Retarded Children and has been, until her transfer, secretary to the

Steering Committee for the forthcoming Federal-provincial Conference on Mental Retardation.

Miss Dorgan is a member of the Council of Social Work Education as well as the Canadian Association of Social Workers, of which she has served in the past as a member of the Board of Directors, and as chairman of the National Nucleus Publications Committee, which is responsible for the publication of the professional journal of the Association.

She has contributed a number of articles to professional journals concerned with social work and psychiatric problems.

In her new position in Civilian Rehabilitation Miss Dorgan will work closely with the provinces in the development of Canada's vocational rehabilitation program and will bring to the task an extensive experience in nursing, social work and in the problems of rehabilitation as they relate to mental illness and mental retardation.

Rehabilitation Offices in Canada

NATIONAL OFFICE

National Co-ordinator,
Civilian Rehabilitation,
Department of Labour,
OTTAWA, Ontario.

PROVINCIAL OFFICES

Provincial Co-ordinator of Rehabilitation,
Department of Health,
Post Office Box 5250,
ST. JOHN'S, Newfoundland.

Deputy Minister,
Department of Welfare and Labour,
CHARLOTTETOWN, Prince Edward Island.

Provincial Rehabilitation Co-ordinator,
Department of Public Health,
Post Office Box 488,
HALIFAX, Nova Scotia.

Director and Co-ordinator of Rehabilitation,
Department of Health,
FREDERICTON, New Brunswick.

Physically Handicapped Division,
Department of Youth,
9175 St. Hubert Street,
MONTREAL 11, Quebec.

Provincial Co-ordinator of Vocational Rehabilitation,
Department of Public Welfare,
85 Eglinton Avenue East,
TORONTO 12, Ontario.

Provincial Co-ordinator of Rehabilitation Services,
Department of Health,
Kennedy & York,
WINNIPEG 1, Manitoba.

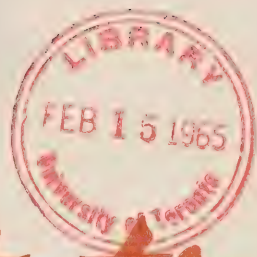
Provincial Co-ordinator of Rehabilitation,
Health and Welfare Building,
REGINA, Saskatchewan.

Provincial Co-ordinator of Rehabilitation,
Department of Public Welfare,
109th Street and 98th Avenue,
EDMONTON, Alberta.

Rehabilitation Co-ordinator,
Department of Health Service and Hospital Insurance,
828 West 10th Avenue,
VANCOUVER 9, British Columbia.

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Rehabilitation **IN CANADA**



Published in the interests of Canada's Disabled by ...

CIVILIAN REHABILITATION

Department of Labour Canada

ISSUE No. 9

CONTENTS

Page

- 4 Hearing and Speech Services in Nova Scotia
- 11 Federal-Provincial Conference on Mental Retardation
- 13 Jewish Vocational Services—Special Services Rehabilitation Unit
- 15 The Nurse's Role in Rehabilitation
- 21 Even in a Small Community—Help for the Handicapped
- 24 Senate Special Committee on Aging
- 30 People and Events

This bulletin is prepared by Civilian Rehabilitation, Department of Labour, with the co-operation of the Department of National Health and Welfare, the Department of Veterans Affairs, the National Employment Service and governmental and private agencies interested in the rehabilitation of Canada's disabled.

A vocational rehabilitation program . . . is an organized program designed to provide a comprehensive range of services to meet the diverse medical, social and vocational needs of all its clients. Furthermore, the separate services must be provided in such a way that they form part of a continuous and well integrated plan for each disabled client.

Walter N. Boyd,
Director of Rehabilitation Services,
Province of Manitoba,
International Seminar on Vocational Rehabilitation,
Copenhagen, June 30-July 3, 1963.

To Our Readers

The ability to communicate easily and rapidly is essential to all our activities of daily living. The inability to hear well, or not at all, is a severe handicap to learning, to employment and independence. The child handicapped by a hearing loss is in a particularly difficult situation. Without special help he will fail to develop his full potential. Happily there are ways to help him and in Nova Scotia a new diagnostic speech and hearing clinic is seeking out the children who are in need of the special services that will enable them to take their places in the future life of the community as self reliant and capable workers.

When we are ill we look to the nurse for essential care and all those attentions that will add to our comfort and peace of mind during the time when we are incapacitated but the nurse has a much more important role than this. She must recognize when it is time for the sick person to pick up the threads of his life again and encourage him to assume responsibilities for his own care as quickly as his strength permits. When the ill or injured person is left with a permanent disability the role of the nurse in providing encouragement, knowledge of ways to cope with impaired function and stimulation of the patient to make efforts on his own behalf assumes major proportions. Some of the functions of the nurse in a rehabilitation setting are outlined in an article emanating from the Manitoba Rehabilitation Hospital.

Services such as these play an important part in the development of a well-rounded rehabilitation program in Canada.

HEARING AND SPEECH SERVICES IN NOVA SCOTIA

By Adam J. Sortini, Ed.D.

In the November 1962 issue of the Canadian Journal of Public Health Dr. Sortini outlined the need for diagnostic speech and hearing services in the Maritime Provinces. On January 7, 1963 the Hearing and Speech Clinic, a division of the Rehabilitation Council was opened in Halifax. Here Dr. Sortini reports on the first year of operation.

The Hearing and Speech Clinic in Halifax is a unique service in the Atlantic provinces. Its first year of operation has disclosed some important information regarding the hearing handicapped in the area and indicates steps that need to be taken if the needs of individuals with speech and hearing difficulties are to be suitably met.

An accurate diagnosis and assessment of the individual's problem is the first step in mapping a proper program of treatment and training and this is a primary function of the clinic.

Testing Program

In testing the hearing of an individual, it is possible to use: (1) gross tests, (2) tuning fork tests, (3) pure-tone audiometry and (4) speech audiometry.

Gross tests consist of asking a patient if a watch tick may be heard, clapping one's hands out of sight to observe a patient's reaction, etc. In tuning fork tests, a family physician or ear specialist will ask the patient if he hears a tuning fork when struck (e.g., 500 cycles per second) and then make a diagnosis as to what type of hearing loss the patient has.

There are several reasons why gross tests and tuning fork tests are not ideal. For example, since a watch tick may be one specific frequency a patient may be able to hear a particular watch ticking but have a serious loss for other important frequencies in the speech range. A hand clap will vary a great deal in intensity according to how hard the hands are brought together—and a hand clap may also be one frequency.

A tuning fork test will provide valuable information but has several drawbacks. For example, once struck, it immediately begins to get softer and is difficult for use with young children.

The most scientific test to use for determining the type and extent of an individual's hearing loss is a pure-tone test and consists of a machine called an audiometer being used to present different frequencies and different levels of loudness. For example, the important speech range consists of approximately 500-4,000 cycles per second. By being able to play a frequency, and (unlike a tuning fork test) be able to maintain any level of loudness for as long as the testee wishes, we can then determine if an individual can hear the low tones in the vowel range—or high tones in the consonant range. Not too infrequently, an individual may be able to hear the low tones in the vowel range, be able to "hear" (in that he knows someone is talking) but if he has a severe high tone loss be unable to distinguish between consonants (e.g., "fin" and "sin", "shin" and "chin", "tin" and "pin", etc). By playing one of the above mentioned tones at a level which can be heard and then reducing it in loudness to where it can just barely be heard we find the "threshold of hearing" (i.e., the patient's ability to hear) for that particular tone. By knowing at what levels a normal hearing person responds and subtracting the levels found for all of the frequencies of the person tested, we are able to determine the amount of hearing loss found for the individual being evaluated.

Finding a "threshold" as described above, may be accomplished by (1) subjective pure-tone audiometry (where the tester plays the different tones and the subject reports orally whether or not the tone is heard) or (2) objective audiometry (where one possible technique is the use of a machine called an electro-dermal audiometer). With this technique one set of electrodes is placed on the calf of one leg, and another set usually on the finger tips of the opposite hand. Then

tone is played, followed by a mild shock. This sequence is repeated several times and the central nervous system is trained to expect a shock everytime it is preceded by a tone. After several trials of tone followed by shock the tone is then played without the shock. If the patient has hearing, in anticipation of the shock, there will be increased sweating under the finger tip electrodes. These changes in skin-resistance are then relayed to an ink writer in wave form and the tester records objectively (i.e., with no subjective response of any kind from the patient being tested) the "thresholds" and plots the person's ability to hear. The electro-dermal audiometer, which is used routinely at the Hearing & Speech Clinic is valuable not only for testing the hearing of infants, even under one year of age, but can be used to aid in the diagnosis of emotional disturbance, mental retardation, or malingering in children and adults (e.g., an adult who is in an accident and claims deafness as a result, desiring large sums of money from insurance companies).

The youngest child tested by this method thus far at the clinic has been four months of age and the youngest child fitted with a hearing aid, eight months of age. The Hearing & Speech Clinic in Halifax, to my knowledge, is the only clinic in Canada using an electro-dermal audiometer for clinical testing routinely and although not infallible it is a most valuable piece of equipment which can be used as one of a battery of tests in order to assess the hearing ability of an individual.

Speech audiometry requires a special piece of equipment called a speech audiometer. The tester is in one room and then presents test words at monitored levels into another room through a loudspeaker, and ear phones, so that the patient's ability to hear and understand speech is measured scientifically. This technique is especially valuable in determining the individual's suitability for a hearing aid.

The Hearing & Speech Clinic has two puretone audiometers, a speech audiometer, an electrodermal audiometer and a Bekesy audiometer has just been added to the equipment. This is a special type of audiometer, which is especially valuable for the diagnosis of middle ear, cochlear and eighth nerve disorders in adults.

When a patient is referred as having a speech problem, several different diagnostic procedures

are carried out in an effort to determine what type of speech problem exists, the possible reason(s) for the problem, and therapy is then undertaken, when indicated, in an effort to improve the individual's speech as much as possible.

Hearing Tests in 1963

For the period covered there were 126 psychogalvanometer tests performed (Table I). Of this number, four were within the age range of 11 to 15 and were done when results obtained by subjective pure tone audiometry were questionable and an emotional disturbance was suspected. The remainder (122) suggest that it was possible to perform this number of special tests with children under five years of age (and for whom subjective testing would not have been possible) and be able to recommend an appropriate hearing aid after the exclusion of medical aid. In those instances where this special type of testing was done and normal hearing found, it was of significant value to the referral source to know that the reason for the existing speech delay was not caused by a hearing loss. Without the existence of our clinic and our being able to put the psycho-galvanometer to use when indicated, it would have been necessary for these children to travel great distances (at considerable expense and time) in order to aid medical specialists in making a proper diagnosis for the existing speech delay.

It has been stated by authorities that to do subjective audiometry with children under six years of age is difficult, and many times impossible. Seventy-one children were tested in this age range by subjective audiometry suggesting that the years of experience and clinical ability of the audiologist played an important role in attempting to diagnose reasons for the speech delay of children seen.

Hearing Aids Required

132 hearing aids were recommended—but a smaller number were actually fitted. In a significant number of instances, although a hearing aid was recommended by the clinic audiologist, the patient came from a great distance and the referral source would take the audiologist's recommendation and then arrange to have the patient fitted in his own geographical area for the sake

of convenience. It should also be noted that no hearing aid was fitted by the audiologist until medical aid was first excluded. Then after the audiologist was so informed, ear impressions were taken and specific recommendations for a hearing aid made, including special settings, receivers, etc., as well as giving the patient (or parents of the patient) instructions in the use and care of the hearing aid. If it was possible to arrange for several weeks of auditory training with the clinic speech and hearing therapist (unless distance made this impractical or the patient was a pre-school child) this was also arranged. It is hoped that consideration will be given to provincial funds being made available for hearing aids, especially for young children. There have been children seen who could benefit significantly from hearing aids who have gone without them because there were no funds available from agencies and/or parents to supply the hearing aids. Mr. Freemantle, the principal of the Interprovincial School for Deaf, as of December, 1963, estimated that there are at least twenty-five children in his school at this time who could use individual hearing aids to great advantage except for the unavailability of funds to procure the hearing aids.

Psychological Evaluations

Regarding the recommendations for psychological evaluations, there were 144 (Table 1) but at least 50 more would have been recommended except for the fact that many patients came from significant distances, were felt to need a psychological by staff members of the clinic but were unable to return or stay over for future appointments because of financial difficulties—and were unable to be seen by the Children's Hospital psychologist on the same day they were seen in the clinic because of no available time in the schedule of the psychologist. We now have a waiting list for psychological evaluations approaching twenty children with no available source in this geographical area to do the psychological evaluations. It is hoped it will be possible to provide the clinic with at least a half time psychologist in the immediate future in effort to give the staff members of the clinic a total picture of the child's abilities before making appropriate recommendations for his welfare.

Speech Evaluations

Of the 164 speech evaluations performed, every conceivable type of speech problem was seen and the age range in therapy at this moment ranges from a 4 year old with delayed speech to a 38 year old stutterer.

Social Worker Required

There are only seven visits noted by the social worker. The one person employed started working at the clinic on March 1st and resigned on March 31st for reason of marriage and we have not been able to replace her since.

Types of Hearing Losses

Table II shows the type of hearing loss found and is self explanatory. The difference between the total number of losses (497) and the total number of hearing tests performed (757) suggests a total of 260 tests were performed which indicated normal hearing. As a routine part of the 164 speech evaluations performed, a hearing test was also done so as to aid in the total picture before making a diagnosis of the patient's problem.

Severity of Hearing Losses

Table III indicates the extent of hearing loss found. 53 children in the pre-school group had losses of 60 decibels or less suggesting that through early diagnosis and treatment 59% of this group has been helped at an early stage so that the possibility of needing special education has been significantly reduced. Also, although 28 patients in the group (31%) had profound losses, (i.e., 76 to 100 decibels) therapy is able to be started now so as to enable them to begin learning language now instead of wasting their early years which have been demonstrated through research to be so valuable for developing language.

Geographical Distribution

The geographical distribution by county for hearing losses is shown in Table IV. 34 patients of all ages were referred from the other Atlantic Provinces. When we combine the patients having hearing losses (Table IV) with those having speech defects (Table V) we see that Cape Breton County has 35 individuals in need of speech

and/or hearing therapy which is surely enough to warrant consideration for having a full time speech and hearing therapist in this area. Lunenburg County has 30 individuals having speech and hearing problems, Pictou, 26 and Hants County 55. When we take into consideration the fact that the losses reported here are only the ones which have been referred to the clinic, it is safe to assume that there are many more children and adults in Nova Scotia not yet reported greatly needing speech and hearing therapy. It is hoped serious consideration will be given to the hiring of speech and hearing therapists for areas in Nova Scotia having need for these services.

Need for Professional Staff Disclosed

It is estimated that about one in every twenty persons has a comparatively serious speech handicap of some sort—almost 900,000 people in Canada. Thus, for the Atlantic Provinces with a population of two million, we can expect 100,000 individuals with a speech problem. At present, there are about seven speech and hearing therapists to handle this amount—which means 14,285 individuals per therapist! When we add to the total of 900,000 people in Canada who have speech problems, another 350,000 of our citizens who have hearing defects serious enough to require such help as speech reading (i.e., lip reading) or hearing aids, we begin to have some idea of the number of people who need the assistance of someone who has specialized in studying the disorders of speech and hearing. It is thus hoped that a college or university in the area of the Speech and Hearing Clinic will seriously consider establishing a training program in the near future for speech and hearing therapists (as well as teachers of the deaf). The School for the Deaf in Amherst could be used as a clinical training centre for prospective teachers of the deaf and the Hearing & Speech Clinic used for training prospective speech and hearing therapists.

Source of Referral

Table VI is self explanatory and shows the source of referral. It would appear that family physicians, otologists and other sources in Nova Scotia are aware of the Clinic and are making use of it.

Causes of Hearing Disorders

Etiology for hearing losses is shown in Table VII. The largest group (202) included individuals with otosclerosis, otitis media, those in need of a tonsillectomy and adenoidectomy, etc. By "undiagnosed illness, unknown" is meant that either one of several factors noted in the case history (e.g., meningitis and measles combined) could have caused the hearing loss found or the entire case history was negative.

In summary there are several factors worth noting:

(1) There were a significant number of children referred to the clinic with hearing losses tested by the audiologist and found to have conductive hearing losses. On being referred to the medical director and otologist, the hearing loss was eliminated on the spot through wax removal or by subsequent treatment. Also, a significant number of adults with otosclerosis (some of whom had worn hearing aids for many years) were operated on by the medical director and post operative audiological testing indicated that, in the great majority of cases, serviceable hearing had been achieved through surgery and hearing aids were discarded.

(2) A number of cases referred as "speech problems" were found to have significant high frequency hearing losses (i.e., an inability to hear the high tones in the consonant range). With speech therapy and a properly prescribed hearing aid most of these patients are now making satisfactory progress.

(3) At this time our present speech and hearing therapists are working to capacity and we are unable to accept any additional cases for speech and hearing therapy. By being able to hire at least another half time speech and hearing therapist we would begin to meet the need for the coming fiscal year.

(4) It is expected that within the next fiscal year in the area of one hundred hearing aids will be needed for children in Nova Scotia with hearing problems. A notable number in this group will go without being able to hear and utilize their native intelligence to develop language unless provincial funds are made available for these deserving children.

(5) It is hoped that consideration will be given to establishing a pre-school deaf class, similar to the one existing in Halifax, in Cape Breton (and other necessary geographical locations as the need arises) staffed with properly qualified teachers of the deaf, with the funds needed to staff and run these schools provided by the provincial department of special education.

(6) A record was kept of patients seen which were placed in a category of "saved" or "could have saved" (for Nova Scotia only). By the term "saved" is meant that seven children (in the period reported) were tested and diagnosed at the Pre-School level and it is felt these seven children, through early diagnosis, and being fitted with hearing aids, will not need special schooling at the time they reach school age. The cost of sending a child to the School for the Deaf is \$2,000. per student per year. This cost is met by the municipality paying \$750. per year (this figure remains constant) and the balance being paid by the government. Thus, for the seven children reported above, at \$14,000. per seven children per year this represents \$168,000. which will not need to be spent over the next 12 years for special schooling as compared to a total annual cost of \$256.81 per child for public schooling (totaling \$21,572.04 for this group). Subtracting the cost of total possible public schooling for those seven children (\$21,572.04) from the potential cost of twelve years of special schooling (\$168,000.)—we see a saving to the tax payer—(and government) of \$146,427.96 over the next 12 years.

In the category of "could have saved" there were ten children seen in the period reported who, in my opinion, would have had a good possibility of not needing to go to the School for the Deaf if they were seen at a clinic such as ours, diagnosed, fitted with appropriate hearing aids, and therapy started at an early age. Using the same basic figures above, this represents an outlay over the next 12 years for the government and taxpayer of close to a quarter of a million dollars, the greatest portion of which might well have been saved with early diagnosis and treat-

ment as is now available with the establishing of the Hearing & Speech Clinic.

The hearing of all children before entering the School for the Deaf is now being checked, and the audiologist and speech pathologist is acting as a consultant for the Halifax School for the Blind and the Nova Scotia Home for Colored Children, periodically examining the speech and hearing of each child. It is now possible when deafness is suspected in the pre-school child to refer the patient to the Hearing and Speech Clinic. If deaf, the child can be properly diagnosed and an appropriate hearing aid recommended—then the child can be enrolled in the Halifax Pre-School Deaf Class, in preparation for the School for the Deaf at Amherst. The one missing link at this time is the lack of funds to provide hearing aids for needy children, when indicated, and it is hoped this will be remedied in the near future.

Conclusions

The statistics and information show:

- (1) A clinic such as the Hearing and Speech Clinic is sorely needed in the geographical area it covers.
- (2) It is being utilized by the available professional sources for referral purposes.
- (3) It is performing a valuable community function.
- (4) There is a need for the establishment of a training centre at a college or university to train speech and hearing therapists, as well as teachers of the deaf.
- (5) There is a need for more speech and hearing therapists being hired to meet the needs of different geographical areas in Nova Scotia.
- (6) There is a need for the establishing of other pre-school deaf classes in the province (and other provinces as well) similar to the Halifax Pre-School Deaf Class with financial support at the provincial level.
- (7) There is a need for available funds to provide hearing aids when indicated for children and adults, after a properly administered medical and audiological examination combined with a social worker's report shows the need for financial help. With children, the

hearing aid can be used to accelerate language development and in some cases, eliminate the need for special schooling. The adult can either acquire a job and not be a financial burden to

the community, or acquire a better paying position so he may work to the full potential of his ability, better support and raise his family.

TABLE I
TYPE SERVICE PERFORMED (visits)
January 7, 1963-December 31, 1963

Age*	0-5	6-10	11-15	16-20	21-30	31-40	41-50	51-60	61-70	71-80	80+	Total
audio test.....	71	177	120	26	32	49	74	43	31	7	1	631
PGSR test.....	112	10	4	0	0	0	0	0	0	0	0	126
speech eval.....	78	64	15	2	4	1	0	0	0	0	0	164
h.a. rec.....	42	28	18	2	3	9	10	11	5	3	1	132
psych rec.....	67	66	10	1	0	0	0	0	0	0	0	144
												1,197
counselling.....												71
ENT.....												195
Paed.....												115
sp. ther.....												596
soc. wkr.....												07
	370	345	167	31	39	59	84	54	36	10	2	984
												1,905

Age breakdown in all tables was included only for services by audiologist and speech pathologist.

* In all tables, the age range noted is 0-5, 6-10 etc., although in tabulating the date, 0-5.11, 6-10.11 etc., was used.

TABLE II--TYPE LOSS

Age	0-5	6-10	11-15	16-20	21-30	31-40	41-50	51-60	61-70	71-80	80+	Totals
Cond.....	28	41	34	11	15	31	29	10	3	0	0	202
Nerve.....	56	79	34	6	7	6	15	21	20	10	1	255
Mixed.....	1	2	6	0	6	5	12	7	1	0	0	40
Totals.....	85	122	74	17	28	42	56	38	24	10	1	497

TABLE III--EXTENT OF LOSS (in decibels)

Age	0-5	6-10	11-15	16-20	21-30	31-40	41-50	51-60	61-70	71-80	80+	Totals
-20.....	6	14	14	4	3	3	3	2	5	1	0	55
1-40.....	19	43	30	7	15	20	18	16	7	1	0	176
1-60.....	28	24	19	6	6	18	24	16	10	4	1	156
1-75.....	9	18	5	0	4	3	3	4	4	2	0	52
5-100.....	28	16	6	2	1	2	1	1	1	0	0	58
Totals.....	90	115	74	19	29	46	49	39	27	8	1	497

TABLE IV
GEOGRAPHICAL DISTRIBUTION BY COUNTY
(Hearing Defects)

Age	0-5	6-10	11-15	16-20	21-30	31-40	41-50	51-60	61-70	71-80	80+	Totals
N.S.												
Hfx.	56	71	53	11	17	28	32	27	18	2	1	316
Hants.	11	11	9	1	3	4	5	1	0	3	0	48
Kings.	3	5	2	0	2	1	2	1	0	0	0	16
Anna.	2	3	1	0	0	0	0	0	0	0	0	6
Digby.	0	3	0	0	0	0	0	0	0	0	0	3
Yarm.	1	1	0	0	0	2	1	0	0	0	0	5
Shel.	0	0	0	1	0	0	1	0	0	0	0	2
Lunen.	3	7	1	0	2	2	3	2	0	2	0	22
Queens.	3	2	0	1	0	0	1	1	0	0	0	8
Pictou.	1	5	2	0	1	2	1	2	1	0	0	15
Ant.	3	2	0	1	0	0	0	0	1	0	0	7
Guys.	0	0	0	0	0	0	0	0	1	0	0	1
Vict.	2	3	1	0	0	0	0	0	0	0	0	6
Rich.	0	1	1	0	0	0	0	0	0	0	0	2
Cumber.	5	4	1	1	0	1	2	2	1	0	0	17
Col.	4	4	4	1	1	0	0	1	1	1	0	17
C.B.	13	6	2	0	0	2	1	1	3	0	0	28
Invern.	3	2	2	0	1	2	0	0	0	0	0	10
Totals	110	130	79	17	27	44	49	38	26	8	1	529
NFLD.	2	0	0	0	0	2	0	0	0	0	0	4
N.B.	3	8	3	1	0	2	1	0	1	0	0	19
P.E.I.	2	4	2	0	2	0	1	0	0	0	0	11
Totals	117	142	84	18	29	48	51	38	27	8	1	563

TABLE V
GEOGRAPHICAL DISTRIBUTION BY COUNTY
(Speech defects)

Age	0-5	6-10	11-15	16-20	21-30	31-40	41-50	51-60	61-70	71-80	80+	Total
N.S.												
Hfx.	32	14	4	0	0	0	0	0	0	0	0	50
Hants.	4	3	0	0	0	0	0	0	0	0	0	7
Kings.	3	1	2	0	0	0	0	0	0	0	0	6
Anna.	1	4	1	0	0	0	0	0	0	0	0	6
Digby.	1	1	0	0	0	0	0	0	0	0	0	2
Yarm.	0	0	0	0	0	0	0	0	0	0	0	0
Shel.	1	1	0	0	0	0	0	0	0	0	0	2
Lunen.	3	5	0	0	0	0	0	0	0	0	0	8
Queens.	1	0	0	0	0	0	0	0	0	0	0	1
Pictou.	1	9	1	0	0	0	0	0	0	0	0	11
Ant.	0	2	0	0	0	0	0	0	0	0	0	2
Guys.	1	0	0	0	0	0	0	0	0	0	0	1
Vict.	0	0	0	0	0	1	0	0	0	0	0	1
Rich.	0	0	0	0	0	0	0	0	0	0	0	0
Cumber.	2	0	0	0	0	0	0	0	0	0	0	2
Col.	4	4	0	0	0	0	0	0	0	0	0	8
C.B.	5	2	0	0	0	0	0	0	0	0	0	7
Invern.	1	2	0	0	0	0	0	0	0	0	0	3
Totals	60	48	8	0	0	1	0	0	0	0	0	117
NFLD.	0	0	0	0	0	0	0	0	0	0	0	0
N.B.	0	0	0	0	0	0	0	0	0	0	0	0
P.E.I.	0	0	0	0	0	0	0	0	0	0	0	0

TABLE VI
SOURCE OF REFERRAL

Age	0-5	6-10	11-15	16-20	21-30	31-40	41-50	51-60	61-70	71-80	80+	Total
Family Physician.....	95	92	38	4	8	10	10	7	7	4	1	276
Otologist.....	17	36	23	14	24	39	51	32	23	4	0	263
Children's Hosp.....	68	44	13	2*	0	0	0	0	0	0	0	127
Pub. Schools.....	0	26	44	2	0	0	0	0	0	0	0	72
Clinics / Agencies.....	17	30	8	2	1	0	0	0	0	0	0	58
Totals.....	197	228	126	24	33	49	61	39	30	8	1	796

*Student Nurses

TABLE VII
ETIOLOGY

Age	0-5	6-10	11-15	16-20	21-30	31-40	41-50	51-60	61-70	71-80	80+	Total
Trauma*	0	0	0	1	1	0	0	0	0	0	0	2
Mumps.....	1	2	2	0	0	0	0	0	0	0	0	5
Rubella.....	5	3	0	0	0	0	0	0	0	0	0	8
Meningitis.....	6	6	3	0	0	0	0	0	0	0	0	15
Presbycusis.....	0	0	0	0	0	7	25	26	20	10	1	89
Cyanosis.....	3	2	1	0	0	0	0	0	0	0	0	6
Jaundice.....	4	3	2	0	0	0	0	0	0	0	0	9
Encephalitis.....	5	3	0	0	0	0	0	0	0	0	0	8
Bill Atresia.....	4	0	0	0	0	0	0	0	0	0	0	4
Undiag. Illness or												
Unknown.....	25	55	28	5	11	4	2	2	1	0	0	133
Measles.....	2	3	4	0	1	0	0	0	0	0	0	10
Mid. Ear. Dis.....	28	41	34	11	15	31	29	10	3	0	0	202
R. H. Incomp.....	2	4	0	0	0	0	0	0	0	0	0	6
Totals.....	85	122	74	17	28	42	56	38	24	10	1	497

*excessive rifle shooting, car accident.

FEDERAL-PROVINCIAL CONFERENCE ON MENTAL RETARDATION

The interest and concern displayed by the delegates from all parts of Canada, who were in attendance at the Federal-Provincial Conference on Mental Retardation held in Ottawa, October 19-22, 1964, indicated the increasing awareness of the problem of the mentally retarded in our society. The delegates, coming as they did from federal and provincial government departments—health, education, welfare, and labour—professional organizations, voluntary agencies

with special interest in this field, labour and business, served to emphasize the complicated nature of the problem and the many interests and services that are involved in providing for the needs of this group of our citizens.

Honourable Judy LaMarsh, Minister of National Health and Welfare, in opening the conference, stressed the need for a co-ordinated approach to the problem. She said "All of us realize that in mental retardation, no one disci-

pline or group has a priority of interest,—they all must dovetail and frequently overlap. At one particular time employment or training, for example, may be of prime concern, but seldom to the exclusion of welfare or health. In fact, this many sided approach is, I believe, an extremely important feature, not only in mental retardation but in any problem where professional help of one kind or another is concerned." In concluding her remarks the minister expressed the hope that the conference would agree on methods which would "assure more practical arrangements for co-ordinating the various federal, provincial and voluntary and professional agencies responsible for providing the diverse services and facilities necessary in this complex field."

In plenary sessions the conference directed its attention to the following areas:

1. Prevention,
2. Detection, Assessment and Counselling,
3. Home Care, Treatment and Continuing Care,

4. Training, Education, Vocational Preparation and Employment,
5. Implementation, Co-ordination and Integration of Services.

The delegates were organized into study groups and in their discussions delved into the roles and responsibilities of various agencies at the federal, provincial and community levels in the fields of health, education, welfare, vocational preparation and placement.

Two guests were present to participate in the conference. Dr. Robert Lafon, Professor of Neurology and Psychiatry at the University of Montpellier, France, was, also, guest speaker at the official luncheon held at the Royal Ottawa Golf Club. Bert W. Schmickel, Deputy Commissioner of Health, Office of Mental Retardation, Connecticut State Department of Health, addressed the plenary session on Home Care, Treatment and Continuing Care.

In the next issue of this bulletin we hope to bring you more complete reports of the proceedings of this conference.

MESSAGE TO THE CONFERENCE

In the twentieth century a philosophy of rehabilitation has evolved which demands that every citizen be given an opportunity to realize and use his capacities to the fullest extent.

As concrete evidence of this new and exciting development, a multitude of facilities and services under government and voluntary auspices are being created. They employ and are directed by individuals with a great variety and range of training and experience.

The rapid growth of these facilities and services is encouraging. It shows that increasingly governments and individuals are recognizing extraordinary needs and are ready and anxious to exert extraordinary efforts to meet them.

The mentally retarded were long neglected and it is important that in our anxiety to make up for lost time we get the most for our efforts. That is why it is good that we pause for a moment in the midst of our activities to review what we have done and hope to do; to assure ourselves that we are going in the same direction and in the right direction.

Let us also remember that while the mentally retarded need our contribution to become, as far as possible, participating members of society, we need their contributions if we are to make the best possible use of our manpower resources.

We must do all we can to ensure that they are given the opportunity to make their contribution.

ALLAN J. MACEachen,
MINISTER OF LABOUR.

JEWISH VOCATIONAL SERVICE

SPECIAL SERVICES REHABILITATION UNIT

The Special Services Rehabilitation Unit was established on an experimental basis in February 1962 to test the feasibility of rehabilitating chronically dependent clients of health and welfare agencies. On January 1, 1963 this service was undertaken on a continuing basis with the assistance of a grant from the Laidlaw Foundation.

The Special Services Rehabilitation Unit (S.S.R.U.) in Toronto consists of a workshop offering paid employment, under controlled working conditions, to selected clients. During the individual's stay in the program, a professionally-trained staff of vocational counsellors and psychologists assesses his basic work potential and, through counselling and manipulation of the work environment, prepare him for employment in the regular labour force or, as a secondary measure, in a sheltered workshop offering long-term paid employment.

Criteria for Admission

Three basic criteria are observed in selecting clients for this service.

1. They must be chronically dependent upon health or welfare agencies or be regarded as potential chronic dependents.
2. They must be physically and mentally capable of coming to the Workshop without assistance.
3. They must be eligible for rehabilitation services within the terms of the Rehabilitation Services Act of Ontario.

Characteristics of Clients

In general the clients exhibit some of the abnormalities observed in clients entering the Jewish Vocational Rehabilitation Workshop which is a quite separate program for convalescent mental patients. However the negative attributes of these clients are more pronounced as they have existed for long periods and have become basic patterns of behaviour. The most common characteristics are:

- (a) lack of a basic concept of the meaning of work in our society, little sense of responsibility and indifference to accepted working requirements such as regular and punctual attendance;
- (b) productivity far below average;
- (c) rigid "personalities" and resistance to changes in their customary patterns of behaviour;
- (d) tendency to withdraw from the stress and strain normally associated with daily living;
- (e) easily upset by work and psychological pressures.

A modest rate of success must be expected with such clients. Nevertheless 74 persons had been served by this experimental program by the end of 1963. There were 55 male and 19 female clients in the group. The largest number were in the 51-60 age range (24) with 19 between 41-50 and 19 between 21-40 years of age. One was under 20 with 11 over 60 years of age.

Over 50% of the group entered the competitive labour force and another 3% undertook a vocational training program following services of the SSRU. Ill health forced 6 to withdraw and one left the city. The other 23 were unable to adapt themselves to the demands of the program.

Improving the Program

Experience has shown the importance of careful selection of clients for the program. Unless the facility can develop measures to identify persons with reasonable potential to benefit from its program, it will dissipate its resources on "hopeless" cases.

Therefore, a major emphasis of the program during the past year has been placed upon the selection of clients. As a means of improving selection procedures, clients considered for the SSRU were placed first in the Jewish Vocational Workshop for a three-week or longer period of observation and assessment.

During 1963 a limited number of convalescent mental patients, who had completed the twelve-week term of assessment and work adjustment training in the Jewish Vocational Workshop but were not ready for referral to regular employment, were admitted to the program. The SSRU proved to be a valuable resource, providing a few additional weeks of work conditioning in preparation for regular employment.

Experience in the program has shown that rushing clients through a treatment program is unwise and frequently sparks a setback in their rehabilitation. Nevertheless, of those served by the program, less than 10% received services over 6 months duration and only 1 continued beyond one year. This tends to affirm the transitional rehabilitative nature of the program.

Throughout the year, new approaches for coping with special problems presented by the chronic-type client were improvised and tested. Although it is still not firmly crystallized, the basic structure of the program is beginning to take shape and is demonstrating the possibility of preventing chronic dependency for a substantial number of persons.

Dr. Kenneth H. Running

All workers in the field of rehabilitation will join with the Department of National Health and Welfare in mourning the sudden death of Dr. Kenneth H. Running of the Medical Rehabilitation Division on July 31st, 1964, while on vacation. Dr. Running joined the Division as Consultant in Physical Medicine and Rehabilitation after his retirement from the Royal Canadian Air Force with the rank of Wing Commander in October, 1961. Dr. Running had served in Europe with the RCAF and undertook four years of postgraduate training in physical medicine and rehabilitation in England and at Sunnybrook Hospital in Toronto. Immediately prior to his retirement from the RCAF he served as Senior Medical Officer at National Defence Headquarters.

During his two years with the Department of National Health and Welfare, Dr. Running served on the Associate Committee on Building Standards for the Handicapped and was active in Developing facilities for children with congenital deformities as well as working to expand rehabilitation programs in Canada for all the disabled. His geniality, courtesy and perseverance will be much missed. He was imbued with the philosophy of rehabilitation as part of the essential development of public health services and worked eagerly visiting rehabilitation facilities in Canada, United States and Europe and as a speaker at various

meetings. He brought to his work conviction, dedication and enthusiasm which were much appreciated by his colleagues and the work of rehabilitation will suffer from his loss.

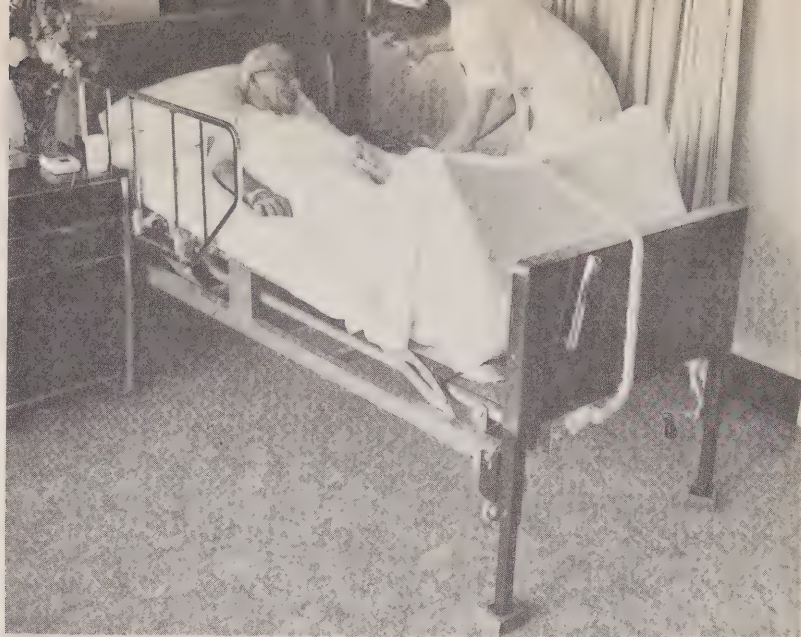
Assistant Co-ordinator Selected for National Defence College Course

R. Noel Meilleur, Assistant Co-ordinator, Civilian Rehabilitation, Department of Labour, Ottawa, has been selected to attend the eighteenth course at the National Defence College, Fort Frontenac, Kingston.

The purpose of the course is to equip senior military and civilian officials with the necessary background of knowledge and understanding of those military, economic, scientific, political and organizational aspects of national security to enable them to take their places effectively in the senior levels of military and departmental appointments.

Mr. Meilleur left to begin his studies on September 8, and will be away until the end of July 1965 when we look forward to having him back to continue his work on behalf of Canada's disabled. He will be much missed by his co-workers in rehabilitation but we all rejoice in this recognition of his capabilities and extend very sincere wishes for success and enjoyment of the studies he has undertaken.

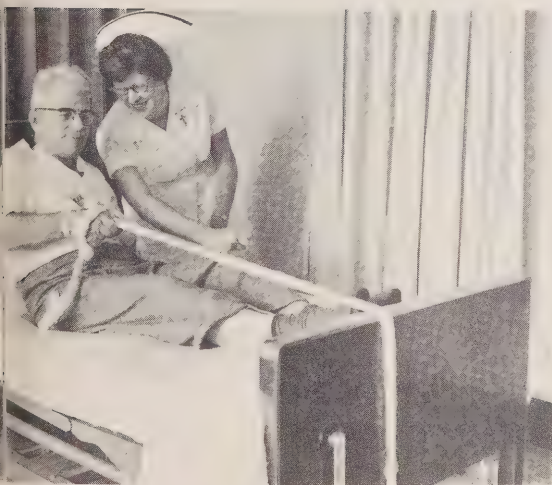
All the aspects of good basic nursing care apply to rehabilitation nursing. Regular and careful noting and recording of the patient's vital signs are particularly important, and the nurse reports any changes to the physician immediately.



THE NURSE'S ROLE IN REHABILITATION

BY PATRICIA HOLTING,

Information Writer, Sanatorium Board of Manitoba, Winnipeg



One of the first things a patient is taught, after he learns to move about in bed, is to sit up and to maintain sitting balance. Here the nurse instructs a patient with left hemiplegia to pull on a bed rope with his right hand. Such special devices are often needed to help a patient maintain a sitting position.

The successful rehabilitation of disabled persons, requires the skills of many disciplines: physicians, therapists, social workers, vocational counsellors and many others. They must all have a clear understanding of the rehabilitation process, the operation of the federal-provincial vocational rehabilitation program, the part he or she plays in that program and the role of other members who will be co-operating in restoring the sick or disabled person to as high a level of efficiency as possible. The nurse has a great deal to do in assisting the individual in his rehabilitation. The Rehabilitation Hospital in Winnipeg has so recognized the importance of the part played by the nurse that it has set up a special course in Rehabilitation Nursing which is given as in-service training to every registered nurse on its staff.



Reversible orthopedic beds help the nurse to care for patients with special needs. The advantages of this type of equipment are that the patient, while being supported on a firm surface, may be immobilized by adding traction to the bed frame; and decubiti are prevented when the patient can be easily turned from supine to prone. The Circ-O-lectric bed here consists of an anterior and posterior frame supported by hoops. By means of electric controls and side levers it can be tilted to any angle, folded to form a chair or swung completely around for patient turning.



In the semi-reclining position of the Circ-O-lectric bed there is pressure on the weight-bearing bones, a factor which helps prevent some of the metabolic complications associated with long-term illnesses.

In the field of rehabilitation a nurse has an exceptional opportunity to practise the highest nursing ideals. In addition to administering the basic bedside care required by any sick or disabled person, the rehabilitation nurse has special duties which require special skills. These are performed in support of the co-ordinated efforts of a group of highly skilled professionals—physicians, therapists, social workers, vocational counsellors and others—who are all motivated by the concept of caring for the total needs of each patient.

Like all other members of the rehabilitation team, every act of the rehabilitation nurse is directed toward fulfilling the aims of the patient's treatment program. Her major contributions are:

The rehabilitation nurse acts as a link between the patient and the rest of the therapeutic team and between the patient and his relatives and the community. Of all the services offered by a rehabilitation hospital, nursing is the only service available 24 hours a day and seven days a week. Because of this central, privileged position, the nurse sees more of the patient's over-all needs, and it is therefore her duty to interpret his hopes and his fears, his frustrations and his feelings of achievement to the other members of the hospital staff and to the patient's family and friends.

The rehabilitation nurse helps the patient to adjust to and accept his disability. She keeps the rehabilitation potential of the patient in mind at all times. Some patients, for example, will completely recover, others will make considerable progress, and a number will have handicaps they may have to live with the rest of their lives.

But even if the rehabilitation goal means only a certain degree of functional ability for self-care, the nurse always takes the positive approach, and while she helps the patient to recognize his limitations, she does not dwell on them. Instead she stimulates and encourages him to develop and use the abilities he has left.

The rehabilitation nurse works closely with the doctors and therapists to help the patient reach his treatment goal as early as possible and at a speed best suited to him. In addition to giving



Independence is stressed throughout the patient's rehabilitation program. Even when immobilized on a Foster Frame, the patient is encouraged by the nurse to perform as many self-care activities as possible. This patient, for example learns to feed herself.

good bedside care, the nurse carries out certain special techniques related to rehabilitation. These may include, for example, prevention of contractures by functional positioning, assistance to maintain range of motion at the joints, practice in crutch walking on the wards and such activities of daily living as are carried out at the bedside.

The nurse can also be of great value to the hospital staff by observing the effect of the treatment program on the patient. In many cases she is able to advise on the patient's attitude and reactions to treatment. The records she keeps are very important. Changes in pulse rate and blood pressure readings are carefully charted, and reports on

In order to assist the patient to practise ambulation, the nurse must know the crutch-foot sequence of the gaits taught in the physiotherapy department. Ready to support him at the waist should he lose his balance, the nurse walks slightly behind and to the side of the patient so that she will not interfere with his locomotion.





Patients are encouraged to get up and get dressed in the mornings and go everywhere in the hospital on their own. Part of the self-care program is the "serve yourself" policy in the cafeteria. Members of the nursing staff are assigned cafeteria duty—they guide the patients in their choice of foods and carry trays when necessary. The cafeteria staff are also trained to assist. Coloured food badges worn by the patients signify the diets ordered by the doctor.



Great stress is placed on passive range of motion exercises which help prevent deformity and maintain mobility of affected parts. The nursing instructor teaches that during abduction-adduction of the upper extremity the shoulder should not be raised.

laboratory investigations are brought to the attention of the doctors as soon as they are received, for these are often the basis for rapid adjustments of the treatment program and medications.

The nurse shares the responsibility for teaching others. A great deal of time must be spent demonstrating and explaining to the patient and the patient's relatives, and to all levels of the nursing staff, how to do things, who should do things and how some ways are easier than others. The nurse has to be constantly alert, watching to see that what she teaches is carried out, because rehabilitation techniques take into consideration not only facility of execution but also the patient's safety:

"Lock your brakes. Never attempt to rise until you are sure your wheelchair is immobile. Feet together. No . . . bring your right foot forward until it is level with the other. Flex your body slightly. Press hard on the arms of your chair. Gently . . . your hands are too far back. Turn your elbows out a little. Now rise."

Teaching is a continuous responsibility. It involves such important things as teaching the

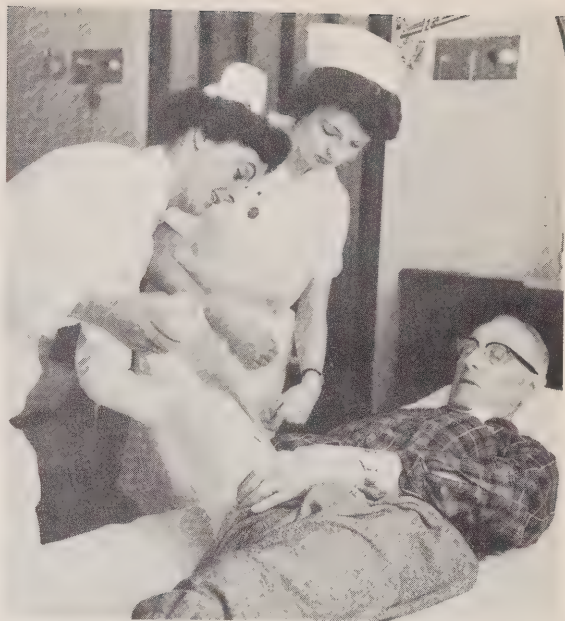
patient the fundamental rules of hygiene, the care of the skin, and bowel and bladder control. It means teaching the patient to provide for his own needs . . . and it means education of the family. The family has an important part in rehabilitation for it is often the relatives' attitude which determines in the long run whether or not the aims of the treatment program will be attained. Members of the family must understand and appreciate the problems encountered by the patient, and they must know how much help should be given and how much should be withheld. Once the patient attains some degree of self-sufficiency, further progress can be hampered by people who would seek to over-protect him—but who, in so doing are, in fact, robbing him of the satisfaction of doing things for himself.

Rehabilitation, the nurse finds, can often be a slow process requiring a great deal of understanding, patience and tact. Unlike her counterpart in a traditional hospital setting, the rehabilitation nurse is never judged on how much she does for the patient but rather on how well she can arouse the patient's interest to achieve things for himself. Her care is highly individualized and all her resources of quiet strength are needed to obtain from the patient maximum response to treatment.

But having successfully completed the job, there is probably no greater personal satisfaction than having had a part in restoring to an individual his dignity, worth and self-respect.

THE REHABILITATION NURSING COURSE

The purpose of the course is to teach the graduate nurse the extra, special skills required for rehabilitation and to give the nurse the necessary knowledge of available services and programs to understand, appreciate and evaluate the work of the rest of the rehabilitation team. Beginning with the philosophy of rehabilitation and the general principles of rehabilitation nursing, the program consists of lectures, demonstrations, practice sessions, discussions and observations of each specialized service at the rehabilitation hospital. The roster of speakers includes the hospital's medical staff and specialist consultants, members of the hospital's treatment



One of the specialized techniques learned by the rehabilitation nurse is the proper procedure for bandaging the amputee's stump. Done in such a way that greater tension is applied at the distal portion bandaging helps to shape the stump to fit the prosthesis.



As part of her training, the nurse learns how to teach the patient the various methods of putting on and caring for braces and other appliances. Now that she has gained sitting balance, this patient with a left hemiplegia is taught to use a foot stool to maintain this balance while putting on a short-leg, foot-drop brace.

departments, the faculty of the University of Manitoba School of Medical Rehabilitation and representatives of the Federal-Provincial Rehabilitation Program.

The subjects covered include, among other things, an anatomical review of the musculoskeletal and central nervous systems, activities of daily living, speech therapy, social and vocational services for the disabled, emotional factors in rehabilitation, nutritional needs, aids to ambulation and the use of special equipment and appliances, including prostheses, braces, splints and casts. Special emphasis is placed on functional positioning, range of motion exercises, skin care and all the problems encountered in the early care of the handicapped patient.



When transferring a patient with left hemiplegia from the wheelchair to the bed, the nurse stresses the angle and placement of the chair, locking the wheelchair brakes, support when needed at the waist and, in this case, stabilization of the patient's paralysed left leg. Before this patient is able to transfer, she must have some measure of standing balance. She grasps the side rail with her unaffected right hand to pull herself up, maintain her balance, pivot and lower herself into the chair.



A nurse puts into practice some specific procedures to prevent or correct deformities caused by arthritis. These include a bed with a firm mattress, bedboards, a foot board and a specially designed backrest. Resting (gutter) splints are especially important in the care of the arthritis patient.

Nurses at the Manitoba Rehabilitation Hospital gain a thorough knowledge of the rehabilitation of hemiplegic, paraplegic and quadriplegic patients. They learn what can be done to help patients with arthritis, multiple sclerosis, muscular dystrophy and Parkinson's disease, and they learn how rehabilitation can be applied to amputees, to patients who are neurologically disabled and to the elderly sick.

In recent years rehabilitation nursing has gained increasing prominence in nursing education programs, and the course at the Manitoba Rehabilitation Hospital has attracted wide interest throughout the country. Many inquiries have been received by the hospital's administrators, and in order to meet the demand for instruction, it is planned to extend the rehabilitation nursing course in the near future to applicants from outside the hospital.

EVEN IN A SMALL COMMUNITY - HELP FOR THE HANDICAPPED

The Story of Goodwill Industries of Southeastern Michigan.

By

Claude W. Whitehead,
Executive Director.

The operation of a Goodwill Industries program in a town of only 26,000 population was described as impractical and unfeasible by the authorities on sheltered workshop operation. They said it couldn't be done, but we did it here in Adrian!

There are many facets of the program in Adrian, however, that make it different from the conventional Goodwill Industries program which consists primarily of reprocessing used goods.

Sub-Contract Work

In the Adrian operation 40% of the income is derived from industrial sub-contract work performed for local industries. Many Goodwill Industries operate an industrial sub-contract program, but very few do the volume percentage that Adrian does.

An important element in this contract program is that 75% of the work is performed by handicapped people who need only the use of hands in order to perform this job satisfactorily and at an acceptable rate. Another factor in the contract program is that most of the jobs performed are long-term, repetitive type operations rather than short run jobs as done in some contract shops where the employee must continually learn a new method. A more specific analysis of the jobs would show that operations include inspection, assembly, packaging, and use of power equipment. Small refrigeration unit connectors are given both visual and gauging inspection by clients with cerebral palsy, muscular dystrophy, or respiratory disabilities. Another operation involves the assembly of small allen set screws into control knobs for automobile accessories. These jobs are performed easily by women with good finger dexterity, and

require very little other physical ability. Other jobs involve the assembly of combination locks and other mechanisms on a post office lock box.

Power Equipment Used

In some operations power equipment is used to exert the physical effort while the worker is required only to position components, push a button, and remove a finished unit. Jigs and fixtures are frequently used to assist the worker in positioning or holding a part and in some instances relieving the worker of making a decision of the acceptability of a finished unit. Simplifying or reducing inspection requirements is very important in working with the mentally retarded group. We also emphasize the importance of careful job evaluation and job analysis in establishing the physical and mental requirements for any job.

Relations with Industry and Labour

Seven industries currently supplying contract work represent the automotive and refrigeration industries, scientific laboratories, and appliance production, corrugated box manufacturing, and government contract. Relationships with local labor unions have frequently been questioned by visitors to our program. A ready answer is usually given that the union members prefer to share their work and give these people an opportunity for self-support rather than pay for their support in tax dollars or gifts to the local United Fund. This attitude by the local union was developed through a series of public relations programs which were designed to show that handicapped people were really ready and able to perform useful work if given an opportunity on the right job, and our shop would pay decent wages to the handicapped.

Surveying the Need

The need for our services in this community was determined by a survey of employment offices, social agencies, and other groups in 1962. It was determined that the largest group needing sheltered employment was the physically handicapped who also had limited education and eventually could perform relatively simple bench assembly type operations. A majority group was also found in the area of mental retardation but we found that this group needed a more intensive program of evaluation and vocational training.

Obtaining Contracts

With these two groups in mind we made extensive contacts in our industrial area seeking simple repetitive jobs that would not require a highly skilled craftsman but the type that we could expect our employees to produce satisfactorily. The jobs were bid for on a piece rate basis determined by normal production of a non-handicapped person. Our bid is favorably competitive because we have lower overhead particularly in the field of transportation, cost of equipment, and buildings. We have a contract committee composed of retired business executives and leading industrial men in our area. This group helps to encourage local industries to support Goodwill through subletting contract work.

Even in the collection of household discards, our program has had better than average success. Two stores, one in Adrian, one in Monroe, are stocked from the Adrian workshop with reconditioned materials. In the reprocessing departments such skills as steam pressing, laundry operation, appliance and furniture repair are taught to the handicapped.

Evaluation and Training

Our vocational rehabilitation services program begins with a pre-intake evaluation of each prospective client. This involves medical examination, psychological testing in some cases, and family, school, and employment records. Often a vocational objective must be established through a series of vocational evaluations—job tryouts in the workshop. The client is then placed

in a training program within the organization or occasionally outside the workshop in a trade technical or business school. Severely handicapped clients are sometimes not feasible for formal vocational training and are placed in a terminal employment position in the workshop.

Placement

The first objective for all clients is placement in competitive employment outside the workshop. Eight handicapped clients were graduated to outside jobs in the first five months of 1964. Our experience in placement has shown that clients do not always have to be trained in a specific skill but the establishment of a good work record is very important. Our contract work prepares the client for a variety of bench assembly type operations.

School-age Clients

In addition to the primary program of evaluation, training, employment, and placement of adult handicapped, we have developed and are now operating the first vocational program for severely handicapped school-age clients in our state. Mentally retarded students with rated I.Q.'s of 65 or below are now being given vocational evaluation and training on a co-operative basis in a joint program with the Lenawee county special education department. Students 14 years of age and older are given classroom instructions in social and personal activities two days of each week and are brought to our workshop for vocational evaluation and training three days each week. The program is carried out in a special classroom-workshop type area that is part of the plant but isolated for more effective operation and instruction. Transportation to and from the workshop is provided by the county school system. A staff member from the school accompanies the students and assists our training director with the workshop activities. The students are exposed to a wide variety of vocational activities which are primarily manual and of an unskilled type and involves all types of jobs which are currently being done in our plant plus a variety of domestic and janitorial type jobs. Detailed records are kept of each individual's performance in all the areas in which he operates.

during his first year in the program. The second year those who have shown adequate progress will be placed in regular vocational training programs for more intensive preparation work after the field of general vocational ability has been established. Cerebral palsied students have been added to the program recently and some of them will be integrated with the mentally retarded after vocational evaluation has been completed. Others will be separated into different areas to work with the physically handicapped because of their individual characteristics and potential learning abilities.

Another cooperative school program involves the mentally retarded with rated I.Q.'s of 65-75 who are considered to be educable as compared with trainable in the group of below 65 I.Q. The educable group attends regular school classes in the morning and works at Goodwill daily in the afternoon where they develop vocational skills of a higher level. Our only problem experienced in this area is limited capacity to absorb the students in the workshop. Normally this program has a term of six months to one year compared with two to three years with the severely limited group. We have better prospects of eventual outside employment placement with the educable group while the slower group will probably be primarily sheltered employment prospects.

With either group at least we are raising their vocational performance level and are probably preventing some from being confined to a state institution for the mentally retarded. In the case of the physically handicapped we have removed them from welfare or relief rolls in providing employment services to them.

Development of Program

Our program had its beginning in 1958 when a committee of the Adrian area of Chamber of Commerce decided something needed to be done to reduce the welfare rolls and give handicapped people an opportunity to help themselves. We began as a branch of the Detroit Goodwill Industries and after local interest increased we became an independent, locally autonomous, operation in October, 1960. The Detroit Goodwill found it necessary to subsidize about 20% of

the program's operating costs and this was reduced to less than 10% by the end of 1961. We are now self-supporting in as much that income from sales of reprocessed clothing, furniture, and other household articles and income from sub-contract work pay the operating expenses.

Purchases of new equipment, buildings, and major improvements are financed from special funds contributed primarily by local foundations.

We are not engaged in any type of manufacturing of new goods although some workshops have found this a good operation for providing additional employment. Our collection of household materials covers a two county area lying between Toledo and Detroit and involving approximately 200,000 people residing in small towns of less than 5,000 population on the average. Only two of our communities are larger: Monroe has 28,000 people and Adrian 26,000. Although Adrian had the distinction of being the smallest city in the United States supporting a totally independent Goodwill Industries, the local unit ranked 91st out of 127 units operating in 1963. This has been the result of total community interest and support and the guidance of a Board of Directors composed of 24 men and women who are community leaders, dedicated to helping the handicapped.

Progress

In six years of operation we have had total income from sales of reprocessed goods, salvage, and industrial services totalling \$348,117.74. Of this \$232,143.31 has been paid in wages in the period through 1963. Ninety-five different handicapped persons were served in 1963 and 12 were graduated from the Goodwill program into jobs in private, competitive business and industry. Earned income for 1963 totalled \$116,013.61 with wage payments amounting to a record \$77,820.08. Seventy-four handicapped people are currently being served in the program including 14 mentally retarded and five cerebral palsied school clients.

The Future

Long range goals are now being established in a two county survey of all agencies, both pri-

vate and government. Special emphasis will be placed on serving the younger handicapped, particularly the mentally retarded because of the increasing problem of youth employment.

Co-operative part-time work will be provided a limited number of public school students in special education categories to supplement school instruction and encourage continued attendance in school.

Other programs to be expanded include senior citizen employment which will include some homebound work.

Conclusion

In summarizing the Adrian story it is our opinion that the small community can support a sheltered workshop operation if it has enough of the right kind of contract work available on a long term basis and if the community is properly oriented as to the program and purpose of the sheltered workshop. The smallness of our town keeps us in better contact with our community and the results are more easily seen and support is generated with a favorable agency image.

If the community wants to enough, it can

PRESENTATION - DEPARTMENT OF LABOUR A SUMMARY

SENATE SPECIAL COMMITTEE ON AGING

A special committee of the Senate of Canada was appointed in July, 1963 "to examine the problems involved in the promotion of the welfare of the aged and aging persons, in order to insure that in addition to the provision of a sufficient income, there are also developed adequate services and facilities of a positive and preventive kind so that older persons may continue to live healthy and useful lives as members of the Canadian community . . ."

In pursuance of its objectives the committee has been hearing briefs and submissions from individuals and organizations with a particular interest in the welfare of the aged.

The Department of Labour has for a number of years been concerned with the plight of older workers seeking job opportunities and through its Division on Older Workers in the Civilian Rehabilitation Branch has been trying to promote a better understanding of the advantages to employers of using the special skills and abilities offered by mature job seekers.

The Department of Labour presentation submitted on July 2, 1964 was made up of two complementary parts. Part 1 is a statistical and research analysis of the problems arising from age which affect individuals in the labour market and was prepared by Dr. Gil Schonning, Assistant Director of the Economics and Research Branch. Part 11 attempts to describe some of the complexities of the social and economic aspects of the older worker problem, its basic causes, its relationship to aging generally, efforts made by the Department of Labour in co-operation with the National Employment Service to create a

more favourable employment market for older workers, and the possibilities inherent in the application of vocational rehabilitation principles and practices to older disabled workers. Part 1 was prepared under the direction of Ian Campbell, National Co-ordinator, Civilian Rehabilitation, by his Division on Older Workers. A summary of this presentation is given below.

Part 1 of the Brief states that considerable interest and concern has been shown for many years in Canada and other countries about the inadequate income position of so many people beyond 65 years of age. In turn, this has led to

more information and understanding about factors which appear to affect the competitiveness of a great many individuals in the labour market especially to the extent that these factors are associated with the age of the individual.

The purpose of the report was to examine and to interpret some of the important aspects of the labour markets, and to show that certain factors operate in the employment markets which make it increasingly difficult, in general, for workers to participate as they grow older.

Dr. Schonning discusses, with the aid of tables and charts, some of the factors which appear to affect the competitiveness of male workers as they age.

Participation Rates and Age

With the exception of the young (under 25) who appear to be preparing themselves for work, the participation rate is very high until age 55 when it drops some 10 percentage points, and of course after 65, when there is a large drop due to retirements. In other words, men participate in the labour force less as they grow older.

Unemployment and Age

By age groups, and again excepting the younger workers, unemployment rates rise slightly with each age group in times of fairly full employment. However, when employment becomes less full, there is a sharp rise in the unemployment rate for the 55-64 age group. This suggests that workers in this group are employable in good times, but expendable in bad times.

Duration of Unemployment

Although younger workers undergo more short-term unemployment than older workers (over 5), the latter undergo more long-term unemployment (over 6 months). In other words, the older job-seekers find it more difficult to get back into employment, and the longer they stay out, the less competitive they become—a vicious circle.

Occupational groups

Working men aged 45 and over constituted some 34 per cent of the male labour force throughout the whole range of occupations, with

larger percentages in managerial occupations, personal services and agriculture. This suggests that where competition depends to a large extent on the individual's knowledge and judgment, aging can be a positive factor, eg., in the managerial group, but where physical effort and/or speed are involved, age may be a negative factor.

Factors Affecting Competitiveness

Basically there are two reasons why workers' employability can be impaired. One is in the characteristics of the employment markets and the other in the workers themselves. Increased demands and new goods and services precipitate different industrial patterns thus causing changes in occupations. These changes also vary from area to area in the country. New technologies alter the requirements for many jobs, and can render obsolete skills learned over the years. To keep up with these changing demands education and training are needed, but it is shown that in general, the levels of education of the older workers are lower than those of the younger ones, thus further reducing their competitiveness.

Suggested Area for Remedial Action in Part 1

Not all the problems of aging can be solved in the employment market, but by learning and understanding more about the relationship between age and employment, many of these problems can be substantially reduced.

As was pointed out earlier, in times of economic buoyancy when unemployment is low, there is little difference in unemployment rates with respect to age, but when the economic momentum slackens unemployment rates rise, particularly in the older groups. Employment activity also varies from area to area. Hence one solution is to find ways and means to stimulate the economy in lagging areas, a program which is now under way.

Changes in industries result in changes in the skills required and often in the location of the workers hence both re-training of the worker and an increase in his mobility are necessary.

The Manpower Consultative Service was set up in the Canadian Department of Labour to assist employers to make better use of manpower and to increase the mobility of the workers affected by technological and other changes.

It is essential to increase resources for getting unemployed workers back to work as quickly as possible, in particular, by increasing facilities for more counselling, vocational guidance, training and re-training.

Co-operation of employers should be sought to find out why a disproportionate number of older workers are released in time of employment changes, and what obstacles there are in times of hirings. It should also be pointed out that age and lack of education are not always valid reasons for non-hiring.

Summary

In Part 1 an attempt has been made to examine how age is reflected in the degree to which people participate in work, the extent and duration of unemployment, and to suggest courses of remedial action.

It must also be borne in mind that due to medical advances and better health care, people are living longer; that rate of production has greatly increased, with a decrease in effort, with resulting increases in leisure. Hence it is imperative to weigh the investment expenditures required to prepare people for changing job situations against the expenditures required to maintain a growing number of retired persons and other non-workers. It is clear that the ability to do both will be significantly enhanced if the rise in real income can be maintained and unemployment kept at a minimum.

Part 11 shows that even though there is a persistent demand for trained workers, many are unemployed for one or more causes: they may be too old, their skills and experience outdated, their education inadequate by modern standards, or they may lack the opportunity to undertake training or re-training courses. In essence these are the principal factors that lie behind the social and economic problem of the older worker.

Prolonged unemployment generally inflicts mental and physical hardships on the older worker particularly when he has dependents. Too,

without income he virtually ceases to be a producer or consumer on a normal scale and so in proportion to his numbers, represents a loss to the economy. There must also be added the cost of various forms of support during his non-productive period, which may be long in the absence of appropriate methods for restoring him to steady employment.

Another social aspect which deserves attention is the effect on the younger members of a family whose parent is unemployed for a lengthy period. This may result in the abandonment of educational plans for the younger members. This in turn, may have a detrimental effect upon their future level of employability.

It is now becoming a generally accepted fact that of all the problems of aging, income is one of the most important. With adequate income at retirement, the other problems—social, psychological, welfare, health or housing, etc.—diminish. The foundation for building this adequate income is steady employment for the fifteen or twenty years before retirement.

The effects of this aspect of the over-all problem extend over time into many areas of human predicament, thus the ultimate solution must inevitably, involve the organized and co-operative efforts of numerous agencies. Governments can give leadership, and have indeed been doing so for some time, but action stimulated by sustained desire to solve a problem of common concern is essential on the part of employers, organized labour, social welfare agencies, educationists, and the public in general.

The Federal Government has attempted to give leadership in this field. For many years the Department of Labour and the National Employment Service, have tried to persuade employers to hire, retain and promote workers on the basis of their ability regardless of age. All types of media, plus personal contacts have been used. These efforts have been widely supported throughout the country to promote a climate of opinion that will discourage age discrimination.

The Federal Government, through the Civil Service Commission, has set an example and removed upper age limits in all but a few special classifications in the federal public service.

The present nature and extent of the problem is a complex result of the population structure and its trends, the operation of the labour market, the rate of technological change, and the social and educational patterns of our changing society. One significant improvement in this situation is the increasing recognition that chronological age is not a satisfactory measure of a person's occupational utility. One of the strongest arguments in favour of greater utilization of older manpower is the fact that the vast majority of the middle-aged and older members of the labour force are employed, often at the peak of their earning power. Why then should some workers in their forties or fifties be considered too old for employment if they suddenly become unemployed?

Some of the most basic reasons might be summarized as follows:

1. prejudice in favour of youth and misconceptions concerning capabilities of older workers;
2. the tendency to generalize about health and mental capacity;
3. the view that generally lower educational levels are an irremediable impediment;
4. rapid advance in technology which render skills and past experience in some measure obsolete;
5. cost factors of group insurance or pension plans;
6. lack of mobility and reluctance to move;
7. promotion policy within an establishment and reluctance on the part of a mature worker to start a new career at the bottom;
8. accelerated promotions of young people who in matters of hiring etc. are likely to favour their contemporaries;
9. seniority provisions in collective agreements;
10. compulsory retirement at age 65 or earlier which discourages the hiring of new employees in their late 40's or 50's; and
11. periods of high unemployment which militate against the rapid hiring of all workers, but particularly against older workers.

Possible measures can be summarized as follows:

1. all out efforts to stimulate the economy and create high employment;
2. measures to encourage the mobility of manpower;
3. continued education, particularly of employers designed to overcome prejudice and present the facts concerning the capabilities of older workers;
4. development of widespread facilities for technical and vocational training and raising the educational qualifications generally with planned encouragement to older workers to participate in training programs prior to or immediately following lay-offs;
5. continuing research to fill gaps in existing knowledge and to provide the information for continuing education;
6. further development of specialized services including individual and group counselling, assessment of capabilities, vocational guidance and placement services;
7. greater use of the science of ergonomics in industry;
8. greater use of portable pensions;
9. widespread study of occupations to determine those most suitable for aging workers; and
10. joint consultation by management and labour in efforts to remove technical and other barriers to the greater utilization of older workers at the plant level.

Vocational Rehabilitation of Older Disabled Workers

Another group deserves consideration and special effort. This group consists of older workers suffering from physical disabilities. Experience to date has shown that vocational rehabilitation—assessment, restorative services, counselling, training and placement can be successful in returning these people to employment or self-care.

The federal-provincial program is fairly well known, but it is not so well known that the program has no upper age limits, and many older people have been and are being successfully rehabilitated, many to suitable employment.

It is widely accepted that age in itself can be a handicap to gainful employment: coupled with a physical disability the odds against a return to employment are multiplied.

Successful rehabilitation of these people with double handicaps, even in relatively small numbers, indicates what might be accomplished for those who are able-bodied and in good health.

Of the 1,814 cases of successful rehabilitation in 1962-63, 407 were aged 45 or over; of these, 227 were rehabilitated into gainful employment in a wide variety of occupations.

Vocational Training or Re-training

It is evident from the statistics presented in Part I that for a large number of older workers their education and skills are inadequate for the jobs available. Program 5 of the Federal-Provincial Technical and Vocational Training Agreements provides for training unemployed persons. Although many older workers have been successfully trained, no data are presently available as to numbers, of those dropping out, or otherwise failing.

In Canada, training, traditionally associated with youth, has not up to now been considered as especially applicable to older persons, although in other countries, notably in the United Kingdom, special methods have been devised. These have not only proved successful when applied to older workers, but can sometimes be applied to the training of younger workers.

It is obvious that while facilities for training and raising the educational qualifications are available to older people, some study and research seem necessary to determine their suitability. Too, re-orientation is needed to convince them that re-training and upgrading of their educational levels is essential if they are to compete in the modern labour market.

International Recognition of the Problem

The social and economic problem of the older worker is not peculiar to Canada or North America as a whole, but is arousing considerable attention in many other countries.

David A. Morse, Director General, International Labour Organization, made the subject the central theme of his report at the International Labour Conference in June 1962.

The Organization for Economic Co-operation and Development is also paying considerable attention to the economic problems of older workers. A seminar was held in Stockholm in 1962 to discuss various aspects of the problem; another was held in 1964 to deal with job redesign for older workers.

It should be noted that, in some instances in Europe where there have been shortages of labour, the problem has been somewhat different than in Canada and the United States. In these countries the main problem has been in persuading older people to remain in or return to the labour market. For this reason the science of ergonomics—the re-designing of jobs, conditions or machinery to help the worker—has assumed a greater importance in Europe than in North America, where the general practice is to transfer the older worker to a less demanding job. The principal advantage of ergonomics of course, is that any re-design of jobs which makes it easier for the older or disabled worker also makes it better for the younger worker.

Federal Government Activities to Counteract the Problem

Shortly after the end of World War II the Canadian Department of Labour and the National Employment Service recognized that the older worker was finding increasing difficulty in obtaining employment despite an extremely buoyant economy.

It was generally agreed that the roots of age discrimination were firmly embedded in the traditional opinions of employers and the public generally and reinforced by the almost universal emphasis on youth. Two world wars and increasing mechanization of industry have tended to strengthen these opinions.

For some years efforts were made to influence the situation by presenting facts in a continuing educational program. Progress has been made although it was not expected to change these attitudes over night.

Interdepartmental Committee on Older Workers

This committee, established in 1953 and still in operation, consists of representatives of various government departments under the chairmanship of Ian Campbell, National Co-ordinator, Civilian Rehabilitation. It gives continuing study to the problem and advises on remedial measures.

The Committee realized that age discrimination arising from prejudice formed the core of the problem but that there were other factors, for example, the steady increase in pension plans.

Shortly after its formation, the Committee decided to encourage continuing educational efforts, and at the same time consider ways to reduce the effects of contributing factors. The need for research in this field was also recognized.

Research

Under the auspices of the Committee a study of the effects of pension plans on the employment of older workers was made; other research has also been carried out by the Economics and Research Branch of the Department of Labour.

Division on Older Workers

In order to intensify efforts on behalf of older workers, the Department of Labour set up, in 1959, a division under the National Co-ordinator, Civilian Rehabilitation.

Its functions include the co-ordination of the activities of the Labour Department in the field; the conduct of a continuing publicity and educational campaign in co-operation with the Department's Information Branch; the encouragement of research in co-operation with the Economics and Research Branch and other interested agencies; the development of liaison with welfare and voluntary agencies, provincial government officials, educationists, management and labour organizations and agencies in other countries; the holding of a watching brief on developments in the field in other countries; and the assembly and dissemination of information directly or indirectly related to the problem of the older worker.

An intensified educational program was begun in 1959 involving liaison with national and provincial organizations and included mass publicity

through such outlets as television and radio in order to enlist support and active co-operation. This program is still being continued.

The opening "broadside" of this long-range program was a letter to employers outlining the problem of the older workers and seeking the assistance of employers.

These letters were sent to some 45,000 employers. Replies representing the practices and opinions of some 15,000 recipients were received. In addition the Labour Department prepared and disseminated information through brochures, booklets, radio talks, speeches, articles in magazines and the "Labour Gazette", television clips, radio announcements, outdoor advertising signs and a film "Date of Birth".

Older Worker Employment and Training Incentive Program

Under this program, initiated in 1963 on an experimental basis, the Department of Labour paid 50 per cent of the monthly wages or \$75.00 per month, whichever was less, to employers hiring workers aged 45 and over who met certain conditions for new jobs in insurable employment. Payments are being made for a period not exceeding 12 months.

Initially the hiring period was for three months—November to January—but was later modified and extended to the end of March. As a result of this program 1,948 older workers who had been unemployed for at least six months obtained jobs.

Conclusion

Age discrimination in employment arises from many causes. An ultimate solution lies in the gradual elimination of the many basic causes. Because of the complexities arising from these varied ramifications of the over-all problem, many groups must be involved. Eventual success, therefore, depends upon the understanding and earnest efforts of employers, labour, voluntary agencies, educationists and all levels of government. All society will gain from the removal of the needless barriers to employment which now exist because of advancing age.

The complete presentation to the Senate Special Committee on Aging is available free from the Division on Older Workers, Civilian Rehabilitation, Department of Labour, Ottawa, Canada.

People and Events

Deputy Minister of Labour Elected Chairman of ILO Governing Body

George V. Haythorne, Federal Deputy Minister of Labour, who has been the Canadian government representative on the Governing Body of the International Labour Organization since 1956 and who headed the Canadian delegation to the 1964 International Labour Conference, was unanimously elected chairman of the Governing Body for a one-year term.

Canada has participated actively in the work of the ILO since its founding in 1919 and this is the third time a Canadian has been honoured by election to the chairmanship.

Exhibition of Arts and Crafts By the Handicapped

On April 29, 1964, Mrs. Lyndon B. Johnson opened an exhibition of arts and crafts by handicapped persons. Paintings, sculptures, ceramics, needlepoint, clothing, toys and other fascinating items held her attention for considerably longer than scheduled.

The exhibition was arranged by the Women's Committee of the President's Committee on Employment of the Handicapped and brought together over 180 individual items of work of persons with all sorts of disabilities including the blind, and mouth and foot painters as well as mentally handicapped persons.

A number of Governors' Committees have expressed their intention to have similar exhibits in their own States.

World Federation of Occupational Therapists Study Course

Following the Third International Congress of the World Federation of Occupational Therapists in Philadelphia, October 1962, six one-week study courses were held, one at the Ontario Workmen's Compensation Board's Hospital and Rehabilitation Centre at Downsview, the others in

Boston and New York. Subsequently six teaching manuals were developed from the content of the courses and these are now available in six separate handbooks which should provide valuable assistance to students and educators. The set includes:

Manual I—Rehabilitation of the Injured Workman.

Manual II—Transitional Programs in Psychiatric Occupational Therapy.

Manual III—Dynamic Living for the Long Term Patient.

Manual IV—Approaches to Independent Living

Manual V—Work Adjustment as a Function of Occupational Therapy.

Manual VI—Approaches to the Treatment of Patients with Neuromuscular Dysfunction.

These manuals are published by Wm. C. Brown Company Publishers, 135 South Locust Street, Dubuque, Iowa, at a cost of \$8.50 per set.

Training and Employment for Retarded

A recent report from the Ontario Association for Retarded Children shows that there are 20 full time workshops in the province providing training and employment to 525 retarded adults.

A certain amount of craft work is done and the products sold. The majority of the workshops carry out sub-contract jobs of various types and one workshop has worked out a plan with the local newspaper whereby the trainees go to the plant and do the collating and preparation for shipment of the daily newspaper.

During 1963 placements of persons trained in these workshops have been made in the following categories:

- Labourer in a small shop
- Stockroom and general clean-up man
- Cafeteria helper
- Elevator operator
- Domestic
- Assistant in a Beauty Salon
- Shop-hand in a small box factory
- Shop-hand in a wood-working shop.

Such an exhibit in Canada would reveal the amazing amount of talent possessed by our handicapped citizens. Any group in Canada interested in organizing one?

New Chairman President's Committee on Employment of the Handicapped

Harold Russell has been appointed chairman of the President's Committee on Employment of the Handicapped by President Johnson to succeed the late Major General Melvin Maas.



Harold Russell will be remembered as the award winning actor who played the role of Homer Parish in "The Best Years of Our Lives". He is also author of a book, "Victory in My Hands" which has become a best-seller. This is the story of how he overcame his disability after a training accident cost him both hands while acting as a paratrooper instructor during the Second World War.

The new chairman has been active in a number of national and international organizations concerned with rehabilitation and welfare. He has served as a Vice Chairman of the President's Committee since 1962.

Mr. Russell was born in Sydney, Nova Scotia, where he lived until his family moved to Boston when he was six years of age.

First Students Graduate

June 19 last was graduation day for the first class in physical and occupational therapy at the School of Rehabilitation Medicine at the Uni-

versity of British Columbia. Fifteen graduated and are now eligible to practice physiotherapy and occupational therapy.

During the first three years the School of Rehabilitation Medicine has grown from an initial class of 19 to an expected enrolment of 30 for the 1964-65 term. In 1965, the School will offer a 4th year course leading to a degree of bachelor of science in rehabilitation.

Canadians Win Prize for Stair-climbing Wheelchair

Two Canadians have designed a wheelchair that can climb and descend stairs and with it have won a prize of \$5,000.00 awarded by the National Inventors' Council, Washington, D.C.

The Council, a United States government agency, had offered the prize for a wheelchair that could go up and down stairs and yet retain its versatility and convenience and be suitable for normal use.

Neville E. Hale and Kenneth Gardner of Hale and Associates, engineering consultants of Toronto, Ontario, have developed a chair which has been judged to meet the specified requirements and to be the best of many submitted from all parts of the world. The chair differs from a conventional chair with larger front wheels and smaller ones which swivel in the rear. A continuous tracked belt is lowered by means of levers to contact stairs when required. The chair is fully collapsible, folding so that it can be carried conveniently in a car trunk.

The inventors are now working to perfect a powered model to be run from a battery.

Our congratulations to Messrs. Hale and Gardner for their enterprise.

Course in Rehabilitation

A training course in rehabilitation held in Winnipeg, June 1-20, was attended by rehabilitation workers from many parts of Canada. The course, which was held at the Manitoba Rehabilitation Hospital, was arranged by the Canadian Rehabilitation Council for the Disabled in co-operation with the Department of University Extension and Adult Education of the University of Manitoba.

Rehabilitation Offices in Canada

NATIONAL OFFICE

National Co-ordinator,
Civilian Rehabilitation,
Department of Labour,
OTTAWA, Ontario.

PROVINCIAL OFFICES

Provincial Co-ordinator of Rehabilitation,
Department of Health,
Post Office Box 5250,

ST. JOHN'S, Newfoundland.
Deputy Minister,
Department of Welfare and Labour,

CHARLOTTETOWN, Prince Edward Island.
Provincial Rehabilitation Co-ordinator,
Department of Public Health,
Post Office Box 488,

HALIFAX, Nova Scotia.
Director and Co-ordinator of Rehabilitation,
Department of Health,

FREDERICTON, New Brunswick.
Physically Handicapped Division,
Department of Youth,
9175 St. Hubert Street,

MONTREAL 11, Quebec.
Provincial Co-ordinator of Vocational Rehabilitation,
Department of Public Welfare,
85 Eglinton Avenue East,

TORONTO 12, Ontario.
Provincial Co-ordinator of Rehabilitation Services,
Department of Health,
Kennedy & York,

WINNIPEG 1, Manitoba.
Provincial Co-ordinator of Rehabilitation,
Health and Welfare Building,

REGINA, Saskatchewan.
Provincial Co-ordinator of Rehabilitation,
Department of Public Welfare,
109th Street and 98th Avenue,

EDMONTON, Alberta.
Rehabilitation Co-ordinator,
Department of Health Service and Hospital Insurance,
828 West 10th Avenue,

VANCOUVER 9, British Columbia.

SPRING

PERIODICALS READING ROOM
(Humanities and Social Sciences)

1965



Rehabilitation **IN CANADA**



published in the interests of Canada's Disabled by ...

CIVILIAN REHABILITATION

Department of Labour Canada

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CONTENTS

Page

- 4 Building Standards for the Handicapped
- 6 Unnecessary Obstacles
- 9 The Role of Rehabilitation in Compensation
- 11 Domestic Training Courses Established
- 12 Nova Scotia Institute of Technology—Handicapped Considered Here
- 16 Conference Report
- 18 The Vital Role Education Plays in Rehabilitation
- 23 The Older Worker in a Changing Employment Environment
- 26 News and Events

This bulletin is prepared by Civilian Rehabilitation, Department of Labour, with the co-operation of the Department of National Health and Welfare, the Department of Veterans Affairs, the National Employment Service and governmental and private agencies interested in the rehabilitation of Canada's disabled.

ROGER DUHAMEL, F.R.S.C.
QUEEN'S PRINTER AND CONTROLLER OF STATIONERY
OTTAWA, 1965



Diane Crow of Brookfield, Nova Scotia—"Campaign Girl of the Year,"
Canadian Paraplegic Association, Maritime Division.

To Our Readers

"Everything important in life seems to be at the top of the stairs." So says Diane Crowe of Brookfield, Nova Scotia.

Diane is sixteen years of age and a paraplegic. In 1963 she was involved in an automobile accident. She has spent a year at the Nova Scotia Rehabilitation Centre and has learned to look after herself and get about on her own in a wheelchair. Now she has returned to high school to continue her education and again join her friends and classmates in the activities of normal teen-age life.

But she has discovered at the very beginning one of the major difficulties to a successful life in the average community for a handicapped person. Steps, steps and more steps . . . steps to the school door, to the church, to the library! The dentist's office is upstairs. The doctor is downstairs which is no help. To get her mail, post a letter or buy a stamp she is beset with a major problem. Three steps at the entrance to the post office are an effective barrier to her entrance unless some of her young friends are about to lend a hand.

She would like to accompany her friend who is shopping for a new dress but the revolving door at the entrance keeps her out of the store. To be sure there is another door but it is too narrow to admit her wheelchair. "Oh well! the dresses are upstairs anyway!"

There are many Diances in Canada who, because of disability, are prevented from a full participation in the life of their communities through the inadequacies of buildings; public buildings, residential accommodation and business or industrial premises.

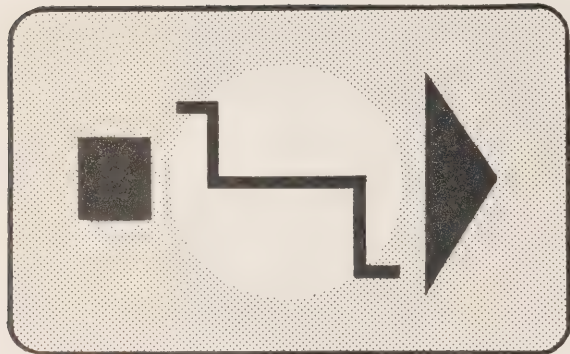
Can anything be done to remedy this situation so that the Diances of our country may live a full and complete life?

A few communities have recognized the problem and have taken steps to improve facilities in their own localities. Their efforts have shown that it can be done with profit for everyone.

Now an important step in developing a national program to eliminate barriers in buildings has been taken. In the article "Building Standards for the Handicapped—Canada 1965", published in this issue, you will see how national recognition has been given to this problem and a major step taken in efforts to alleviate it.

BUILDING STANDARDS FOR THE HANDICAPPED

CANADA 1965



This insignia has been designed for use as a directional sign to building entrances usable by semi-ambulatory and non-ambulatory persons. It is also intended to serve as an identification symbol on all facilities provided for the handicapped.

During the past year or two, anyone scanning through rehabilitation journals will have noticed an increasing reference to the term "Architectural Barriers". The phrase has recently become a part of accepted terminology. It is noted regrettably by architects, used vindictively by rehabilitation workers and accepted as inevitable by the physically handicapped themselves. Implied in the term are the numerous obstructions created in building and planning which prevent disabled persons and others from using many of the buildings and facilities which are essential to an active and useful life—imposing flights of steps, doors which are too narrow and washrooms inaccessible by wheelchair.

In rehabilitation circles, and indeed in the community as a whole, there is a growing awareness of this problem—a live interest which has injected an infectious note of optimism. The surprising fact, however, is not that we suddenly feel something should and can be done about it, but rather, that it should have taken us so long to reach this point. We have been so busy worrying about research, treatment, appliances and the cost of welfare that we were prepared to live with a problem even though it tended to sabotage

almost every rehabilitation plan. Away from rehabilitation circles the indifference has been even more marked. Seldom did a school board member give any thought to that flight of steps at the local school unless it happened to be his own youngster who was confined to a wheelchair or had to use braces and crutches. Nor did anyone object to that rising mound of steps at the church until his doctor quietly took him aside to remind him that he was not as young as he used to be or that his heart was overworked . . . Today there is every indication that the current attack on architectural barriers is beginning to show results. There is reason to feel that there will come a time when it will be a good deal easier for persons whose mobility is impaired by age or physical handicap to find a place to live, a job to do, a school to attend or a church which they can enter without having to be carried up and down the steps.

Partly responsible for this note of optimism has been the work of a small group of people meeting under the auspices of the National Research Council in Ottawa as a subcommittee of the Associate Committee on the National Building Code. This committee comprised of representatives from the Departments of Labour, Health, Welfare and several Voluntary Agencies has produced a document known as "Building Standards for the Handicapped, Canada 1965" as Supplement No. 7 to the National Building Code of Canada. Although set up in technical form for use by architects and builders, this document has broad implications and will serve as a useful guide for anyone who requires details and specifications in planning and building, as well as those engaged in rehabilitation services and physically handicapped persons doing their own planning. The purpose and scope of the document are outlined in Chapter I in these terms.

"These Standards, supplementing the National Building Code of Canada, are intended to make

public buildings accessible to and usable by the physically handicapped without assistance. The application of these Standards in the construction or remodelling of buildings used by the public will help the physically handicapped to participate in many additional community activities."

"These Standards are concerned with the use of buildings by persons who are non-ambulatory or semi-ambulatory or suffer from disabilities of sight, hearing and co-ordination, and disabilities of the aged."

Included in the 20 page booklet are sections dealing with site development, curbs, walks and parking lots, as well as entrances, ramps, stairs, toilet rooms, elevators, telephones, water fountains, etc. It makes reference to fixtures, hardware, switches and controls and lists specific dimensions of wheelchairs and the space requirements for the functioning of a person in a wheelchair or on crutches.

In preparing this document the committee had recourse to the American Standard Specifications for Making Buildings and Facilities Accessible to and Usable by the Physically Handicapped. Extensive research had already been carried out under the leadership of Professor T. Nugent of the University of Southern Illinois where in 1960, 181 severely and permanently disabled students attended on a full time basis. This research encompassed varied disability groups and recommendations were worked out on the basis of average needs. The committee also had recourse to a manual, "Designing for the Disabled," published by the Royal Institute of British Architects which contains about 236 pages of specifications and valuable detail to cover almost every possible variation. Good use was made of both publications. Moreover, in finalizing the Canadian Standards, draft copies were mailed to over 300 interested organizations and individuals for criticism and comment to ensure that the end result would be an acceptable and a representative document. The committee feels it now has such a document and the next step is to find a way which will ensure that the recommendations contained therein will be implemented.

As a start N.R.C. will publicize the supplement to be used with the 1965 issue of the National Building Code. Eventually a copy should be in government offices connected with planning and

building, as well as in the hands of architects, builders and private contractors. Copies of the supplement will be available for wider distribution. The document itself, however, will have no legal status unless a municipal or civic body formally takes steps to make it mandatory by adopting these standards along with the Building Code. In this regard a good deal of work remains to be done and rehabilitation agencies along with other groups and private citizens can do much to see that these standards are implemented within their own communities. How much of a selling job is required may depend somewhat on the approach which is used. In the introduction to the Standards it is noted that almost one out of every 7 Canadians has a permanent physical disability or an infirmity associated with aging. This would mean that in varying degrees more than 2 million people may be affected by such action. Not only are these people prevented from participating in the normal social and recreational life of the community but a percentage of this total is held back from gainful employment because the buildings where jobs might be available are not accessible to them. Equally important is the statement in the foreword which points out: "It is to be noted that implementation of the Standards will in no way detract from the normal use of buildings or facilities by those who are not handicapped. In fact, it will make buildings more accessible and safer for all who use them while ensuring for the handicapped and the aged a happier, fuller and more productive life."

One way of promoting the implementation of the Standards which was found to be quite effective is the use of community surveys to determine what buildings and facilities are accessible to the physically handicapped. Such surveys have resulted in a directory or guide which can be used by the handicapped when searching for an apartment block, a hotel, or a barber shop which is accessible. But, more important, the person to person contact with the building owner or manager in making the survey has ensured that the next building which he helps to plan will not have the same obstacles. Over fifty U.S. cities now either have completed or are planning community surveys and more than twenty States have enacted some form of legislation to implement the Standards. Progress is also evident in

other areas. Several hotel-motel chains are now providing special facilities to accommodate wheelchair guests and Hertz Corporation is considering rent-a-cars with hand controls in major cities. In Canada a certain amount of ground work has also been done by various agencies and individuals and the results are encouraging. In Winnipeg, a survey using volunteer help from a Ladies Auxiliary group was carried out this winter. A directory will be published and the survey work will provide a guide for other communities who may be interested.

Although Building Standards for the Handicapped has now been published, it is hoped that the committee under N.R.C. sponsorship will continue its study and complete the work it has begun, for it must be remembered that architectural barriers in public buildings are only one part of the problem. The matter of residential accommodation deserves at least equal importance. For the disabled person, a place to live is the starting point towards the community life which we tend to stress. The committee has given

some thought to this aspect and plans to involve representatives from Central Mortgage and Housing so that residential standards for the handicapped can be developed. In time, perhaps this can become a part of every public housing project on a percentage basis.

In addition, it would seem desirable that the study and planning should extend into the community as a whole and go beyond the minimum physical requirements. It should take into account the kind of provisions which will not set the disabled as a group apart but, rather will enable them to participate freely in a normal way along with other members of the community. Whether at church or at the hockey game, the disabled person would like to enter unaided, buy his ticket at the door, and sit with his family or friends—rather than be wheeled in under special arrangements and relegated to a section reserved for the handicapped group. With the publication of "The Standards," a good start has been made, but all of us have much more work to do.

UNNECESSARY OBSTACLES

By *Liliane Petit*

The following article is reprinted from the November 1964 issue of *World Veteran* and reflects the international concern with the problem of *building barriers*. In introducing the article the editor of *World Veteran* outlines the problem so clearly that we quote him verbatim: "The concept that a physically handicapped person should be able not only to enter and leave his home with ease, but also to move about outside his home, seems obvious and beyond any discussion. The truth is, however, that this is not always the case. Millions of handicapped persons suffer from limited mobility as a result of unnecessary architectural barriers in the design and construction of buildings. It is particularly important at this time, when there is much new construction throughout the world and when many old buildings are being renovated, that architects, builders and public bodies be aware of the problem. Excessively narrow doors, corridors with sharp turns, public buildings without lifts or with flights of steps as the only access can easily be avoided.

Sound signals for the blind, light signals for the deaf can be provided. The individual home should offer all means of independence and not be a bottleneck."

The author of the article, Mrs. Liliane Petit, whose husband was severely handicapped, is Director of the French Association for the Housing of the Severely Handicapped.

The physically handicapped person who cannot enter and leave his home, go to work and return without difficulty, even though confined in a wheelchair, may be considered in nearly all countries as a privileged person. And yet, he is nevertheless a sort of prisoner, condemned to work but without the right to any leisure. How, under present conditions of town-planning, can he go to the theater or cinema or visit a museum, or how can he do more mundane things such as going to the town hall, to church, or to a shop?

Nearly always, steps rise up as a barrier between him and the rest of the human race.

The problem of housing the physically handicapped seems to be a sort of "discovery", which, if we think about it, is easily explicable. Ten to fifteen years ago, the physically handicapped person was still considered as something of an outcast. Consciously or unconsciously, the passer-by avoided looking at a person on crutches, walking with sticks or sitting in a wheelchair, while it was the duty of the handicapped person not to let himself be seen by able-bodied people.

It may be questioned whether all that is really a thing of the past: even today, it is so much easier and more comfortable to ignore the problems raised by the handicapped!

Their numbers have vastly increased, particularly on account of the increasing number of accidents of all sorts. Those who escape death, frequently remain paralyzed. The problem, therefore, requires further consideration. Handicapped persons who had experienced an active life before their illness or accident no longer accept being relegated to the position of lookers-on confined to the shadows of a dwelling which they cannot leave.

On a world-wide scale, this change of attitude was caused in the first instance by the energy of the paralyzed themselves, but also thanks to men of goodwill who took a hand in reintegrating the handicapped into working life. The result is that, once this development is achieved, we have this desire in all countries to transform housing in general; not only housing but town-planning must be reconsidered. It can no longer be accepted that purely material obstacles should continue to rise as architectural barriers to the reintegration of the handicapped. For not only are public buildings, town halls, schools, post offices, banks, churches and shops built in such a way that it is often impossible for the disabled to use them, but the height of the steps leading to them and the narrowness of the doors constitute obstacles which it is difficult to overcome without outside help.

The psychological, economic and social repercussions are too great for us to remain indifferent to them.

Those who have understood the extent of this "bottleneck" should assist in overcoming the difficulties which arise on all sides.

I recently had the occasion to meet at an international conference a number of doctors dealing with problems connected with the handicapped and I realized that, if we were united, we could form an international army to fight against these architectural barriers which, in the last resort, are no advantage to anybody. Let us re-plan, together with the town-planners, the doctors and the financiers, the towns of tomorrow.

In many countries national associations of the handicapped have been formed. Their first aim, when they come to studying the last link in the chain of resettlement, i.e. appropriate housing, is to draw up standards which we should all like to see adopted throughout the world, not only for the advantage of the permanently handicapped (the paralyzed, whether in wheelchairs or not) but also, of the temporarily handicapped (injured, pregnant women, rheumatic cases, those with heart complaints, haemophiliacs, young mothers pushing perambulators, etc.) and old people.

The most important question is that of access to the building and apartment. I do not share the point of view of those people who would like to see the handicapped living on ground floors only, for I have frequently noted that they prefer to live upstairs providing there is an easily accessible elevator large enough to accommodate them in a wheelchair. When their work and way of living allow, the handicapped also like individual houses, although this is not always possible. In the cities, where work is easier to find, the only individual houses available may be at too great a distance from the center, and traveling difficulties, that "plague of the cities", rarely render this solution possible. But in smaller towns and country districts, the house "made to measure" in accordance with the nature of the handicap of the person concerned is an excellent solution.

Secondly, the associations of handicapped, particularly those which specialize in housing, have undertaken the construction of buildings in accordance with standards worked out in advance.

There are isolated cases of model centers, the size of a small town, designed for the handicapped, of which the able-bodied may also take advantage.

In one French city, all the curbs in the town center have been made to slope down towards the road at pedestrian crossings.

The abolition of certain architectural obstacles has been due to the fact that, notwithstanding the opinions of certain architects, it is possible to replace steps by ramps with a slope of less than 1 to 20. All that is required is to bear this in mind when drawing up the plans. The width of doors does not present any problem; it is sufficient to know that they should have a minimum width of 80 cm and that 90 cm would appear to be a reasonable width for allowing a wheelchair to pass through them with ease.

The sort of new town-planning which we want is above all a state of mind.

We are very glad that we succeeded in having included in the Agenda for the 10th Congress of the International Society for Rehabilitation of the Disabled, which will take place at Wiesbaden, Germany, in 1966, the subject: "Housing for the Disabled". The problem will then be discussed at international level. Who can foresee the results of such discussion?

In addition to the ignorance of too many people who ought to be acquainted with problems connected with housing for the handicapped, there is a financial question. Questions of finance if dealt with reasonably, should never be an obstacle.

The lack of appropriate housing often involves considerable expenditure by unnecessarily prolonging the disabled person's stay in hospital and preventing him from working. Otherwise, he would be a taxpayer instead of an assisted person. This point of view is one of the basic conceptions of modern rehabilitation, where properly adapted housing and the disappearance of unnecessary obstacles are factors of the first importance.

The part that can be played by the authorities in solving the problem should not be underestimated. One example of what can be done with the understanding and support of the authorities is provided by Denmark where an extensive project on behalf of the disabled is at present being put into execution. This is the building of a housing estate at Sundholm, near Copenhagen, which will include a building containing more than 200 apartments, a home for old people with a capacity of 40, a house to accommodate 200 workers, half of whom will be disabled, a workshop and a vocational training center where 1,200 persons will be trained every year. In addition, there will be about 600 smaller apartments. A considerable share of the work will be done by the pupils of a rehabilitation center.

There is no doubt that, if properly studied, the problem of specially adapted housing and town-planning will bring about a number of improvements which will be among the most remarkable of our century which is already rich in transformations, both from a psychological and economic, and even esthetic point of view.

International solidarity will find a magnificent field of expression in fighting for this cause.



THE ROLE OF REHABILITATION IN WORKMEN'S COMPENSATION

By H. Worling,

Chief Rehabilitation Officer, The Workmen's Compensation Board, Ontario

The year 1965 marks the beginning of a second half century of service by the Workmen's Compensation Board of Ontario. It seems an appropriate time to present this review of their outstanding program devised for the benefit of Ontario workers.

The early legislation provided only monetary compensation for wages lost due to accidents at work. Enlightened thinking over the years has led to improvements in legislation and the development of medical and rehabilitation services that have been widely studied and copied.

The federal government, in passing the Vocational Rehabilitation of Disabled Persons Act, has endeavoured to assure that all citizens of Canada who are disabled through non-industrial accident or disease may have the benefit of similar services.

Before 1914, Ontario had adopted the common law principle of England, which provided that the employer was liable for damages for his negligence in respect to accidents to his servants. In practice, however, the prospect of recovering from the employer by the injured workman was barred by the defences of contributory negligence, voluntary assumption of risk, the negligence of his fellow workmen. The suit in the courts was a costly, tedious and bitter struggle and even where the plaintiff was successful, there was no guarantee that he would collect damages. On the other hand, the liability of the employer was individual and unlimited.

In 1910, Sir William Meredith, an eminent jurist, was appointed Commissioner to investigate the whole matter. In his report he set out what were in his opinion the principles on which a firm and equitable statute might be founded. The Workmen's Compensation Act of Ontario, which resulted from this, became effective January 1, 1915. It has been amended periodically to bring it in line with social and economic developments.

Workmen's Compensation Acts are provincial legislation. Federal Government employees are covered by a special Federal Act. This Act utilizes

the legislation of the province where a federal public servant is usually employed. The Yukon and Northwest Territories are covered by special legislation. Cases cannot be transferred from one jurisdiction to another e.g., from W.C.B. British Columbia to W.C.B. Ontario, etc.

The Ontario system is in effect a system of collective liability, administered by a Board having final administrative authority and complete freedom from court interference and control. The decisions of the Board are authorized by law to be made on the "real merits and justice of the case and not bound to follow strict legal precedent". The responsibility thus placed upon the Board is more extensive than under most other systems.

Our responsibility is twofold; first, to the injured workman, and, secondly, to the employer. This second may be taken to include society in general and the state through the provincial legislature.

In the Province of Ontario, it is the Board's function to set the assessment rates on industry, audit employer payrolls, issue and collect the assessments, invest the proceeds for the provision of pensions for the disabled, widows and

orphans, and disburse funds as required for administration, compensation and medical care and rehabilitation.

As trustees of the funds we raise, we are responsible to those from whom we collect funds as well as those to whom treatment or awards are a right under the Act. Employers receive, early each month, a statement of all costs on their injured workmen during the preceding month. With such responsibility, were the operations of the Board anything but efficiently administered, this would be quickly reflected in our operations and adversely affect the present high esteem in which the Board is held, let alone the fame of its fine programme, which is of world renown.

The Ontario Act, according to International Labour Organization standards, meets all the requirements of an ideal Act. Since the Ontario Act came into effect in 1915, its provisions have not only been widely praised; they have also been widely copied.

The Board has exclusive jurisdiction in all matters pertaining to compensation and there is no appeal to the courts by statute. Decisions of the Board are not bound to follow strict legal precedent and the Act states that "the decisions of the Board shall be on the real merits and justice of the case". Dr. E. C. Steele, Commissioner, earlier stated "unimpeded by legal quarrels in the courts, divorced from political interference, and invulnerable to vested interests with the profit motive, the Board can concentrate its efforts and focus its attention on what we have long considered to be the goal of the compensation process—successful rehabilitation". Our objective in every case is to assist the injured workman to return to his job as quickly as possible with the minimum impairment.

The projection of this compensation philosophy has resulted in Ontario adopting a biological or clinical approach to the compensation process rather than an adversary or forensic system.

Rehabilitation in the broadest meaning of the term is an indivisible part of the entire compensation system. We, like other observers, have been unimpressed by the many attempts to graft a rehabilitation programme on to a purely forensic system which inhibits the rehabilitee from accepting such services until the court settlement is completed.

Rehabilitation is a continuous process in which there should be no gaps in treatment, financial or vocational assistance from the time of the initial injury to the return to gainful employment.

We have many definitions of the word "Rehabilitation". However, despite many interpretations existent among those engaged in this work, there is universal agreement on one point: for rehabilitation to be successful there must be adequate medical care to restore the individual to his maximum potential with no limitation on either time or dollar amount.

Medical Care

By statute, wide powers are vested in the Ontario Board and it is mandatory for us to assume complete responsibility for medical care in all its aspects. Section 51 of the Act, after stating medical aid shall be unlimited as to extent, time or costs, states "Medical aid shall be furnished or arranged for by the Board as it may direct or approve"—"All questions as to the necessity, character and sufficiency of any medical aid furnished or to be furnished shall be determined by the Board".

You can readily see the law places a grave responsibility directly on the Board for the medical care of any injured workman entitled to treatment under the Act. The legislators of the Workmen's Compensation Act of Ontario, supported by both management and organized labour, have decreed the Ontario workman is entitled to and shall receive the best medical care and surgical treatment available in the province.

Ours is a democratic country and we are convinced the workman should have the initial free choice of physician, surgeon, or hospital but the Board reserves the right to control the treatment of any case. We are also convinced that the injured workman is better treated and cared for in his local community whenever adequate facilities and skills are available. However, we have many claimants who have suffered severe injuries who cannot be adequately cared for in the more remote parts of our large province. Where the services of specialists may not be available, all such injured workmen are taken to the nearest centre where adequate treatment resources are available.

(Continued on Page 20)

DOMESTIC TRAINING COURSES ESTABLISHED

A concern for teenage girls who, because of mild mental and physical disabilities, found themselves lacking a sufficiently high educational standard to be eligible for vocational training, led to an experiment in Regina that has established guidelines for a developing program in Domestic Training in Saskatchewan.

With the assistance of the Co-ordinating Council on Rehabilitation (Saskatchewan) an advisory committee including representatives of the Co-ordinating Council, the Department of Education, the Department of Public Health, the Regina Public School Board, the Harrow de Groot School for the Mentally Retarded, the National Employment Service, the Saskatchewan Council for Crippled Children and Adults and the Regina Council of Women was established.

Six students were selected for this experiment. They ranged in age from 15 to 18 and suffered from such disabilities as cerebral palsy, hemiparesis and epilepsy. In addition they were all persons with a low level of educational achievement.

Instruction was provided by classroom teaching and practical work at the Physical Restoration Centre and the Harrow de Groot School. In addition a group of women who were interested in rehabilitation provided practical instruction in their homes. One day each week was spent in these selected homes.

Subjects covered included child care, cooking, nutrition, cleaning, laundry methods, sewing, meal planning, shopping and money management. A

good deal of time was spent on personal hygiene, grooming, deportment and work attitudes in an effort to prepare the girls socially and psychologically for the working world.

At the conclusion of the three months course, two girls had jobs waiting and three more went home to use their training there. The sixth girl was thought to be not yet ready for regular employment and a training-on-the-job situation was being sought for her.

The girls showed many personal gains. Nutrition improved, work tolerance increased and the girls learned to organize their work for increased output.

The interest of the community was very evident and more homemakers than required offered their services to provide home instruction. Requests for graduates of the course began coming long before the course ended and every agency represented on the committee had a list of prospective students for the next course.

This experiment led to the drawing up of regulations for the holding of such courses under the provisions of the Technical and Vocational Training agreements and three courses were held in Saskatchewan in 1963. Ten girls graduated from a course at the Harrow de Groot School in Regina, twelve were trained at the Weyburn White Cross Centre, largely persons suffering from chronic-mental illness, and ten at a course in Saskatoon conducted by the Saskatchewan Council for Crippled Children and Adults.

Essay Contest

The Newfoundland Department of Health in co-operation with the Federal Department of Labour through its Federal-Provincial Vocational Rehabilitation Program sponsored an essay contest throughout the high schools of the province last spring. The response was most gratifying and the young people who participated showed considerable insight into the problems and needs of the handicapped. The subject assigned was "The Role of Education in Rehabilitation." We reproduce on page 18 the winning essay. Second and third prizes went to Rosanne Malone, Grade XI student at Holy Heart of Mary Regional High School, St. John's and Sandra J. Poole, Grade X student at the Norris Arm Amalgamated School.



THE NOVA SCOTIA INSTITUTE OF TECHNOLOGY—A federal-provincial project, the multi-million dollar Nova Scotia Institute of Technology located in Halifax, was completed in 1963 and officially opened in May 1964. Designed for "internal flexibility and external expandability" the school, because of the nature of its courses, has ample room for 1,100 students.

NOVA SCOTIA INSTITUTE OF TECHNOLOGY

Handicapped Considered Here

For rehabilitation cases such as Dennis Doyle, the Nova Scotia Institute of Technology provides vocational training which otherwise would not be available to the handicapped in Nova Scotia.

Dennis, confined to a wheel chair as a result of pressure on the spine, is taking mechanical technology.

The Institute, designed with the needs of the handicapped in mind, features ramps to transfer wheel chair cases such as Dennis to all parts of the building.

The elevated outside ramp enables Dennis to convey himself to classes without help. Three additional inside ramps transport him easily from one floor to another.

A ramp especially built for Dennis provides his wheel chair with additional height to permit him to work the lathe.

And the portable drafting boards can be lowered to allow him to work directly from his chair.

Approximately 60 per cent of the rehabilitation cases in the province are being trained at the Institute. At present, of the total enrolment of 307 students, 54 are handicapped.

In order to qualify the handicapped cases pass a medical assessment to determine for which courses they are best suited.

The courses include commercial (stenography), construction sheet metal, cooking, diesel mechanics, gasoline power tool repair, machine tool operation, mechanical technology, oil burner installation and servicing, pipe fitting, radio and TV electronics, radio and TV repair, tile setting and welding.



HANDICAPPED IN MIND—The Nova Scotia Institute of Technology designed with the handicapped in mind features an outside ramp for the convenience of wheel chair cases. For rehabilitation cases, such as Dennis Doyle, the ramp provides easy access to inside classes.

Most of the courses are from six to eight months in length with the technology courses taking 24 months to complete. The entrance requirements vary with each course.

Rehabilitation cases are paid an allowance according to their marital status and location.

Located in Halifax the Nova Scotia Institute of Technology was completed in 1963 and officially opened in May 1964.

A joint project of the federal and provincial governments, the school, modern in every aspect, was designed for "internal flexibility and external expandability."

INSIDE RAMPS—Dennis greets the registrar counsellor, Warren Allan, on his way from one level to another by means of a ramp, one of three inside the building. The ramps are wide enough not to cause confusion and can accommodate a number of students at one time.





RAMP ESPECIALLY BUILT—The course of mechanical technology includes the operation of the lathe. A ramp especially built for Dennis provides his wheel chair with the additional height necessary for the operation of the machine.

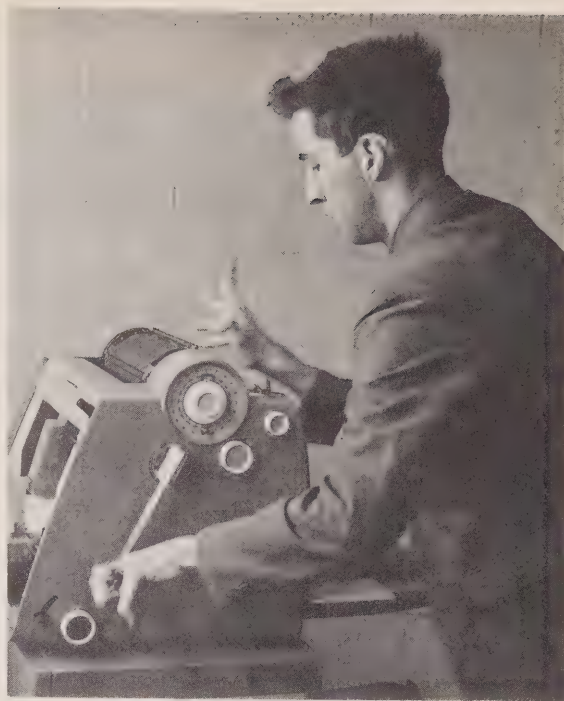
PORTABLE DRAFTING BOARDS—Another feature of the Nova Scotia Institute of Technology and a convenience for rehabilitation cases are the portable drafting boards which can be raised or lowered as needed. Here Dennis can lower his board in order to work directly from his wheel chair.



OPERATING THE LATHE—The ultra-modern Institute of Technology possesses the latest in equipment. In the machine shop, by means of an elevated ramp, Dennis works the lathe, part of his mechanical technology course.



WATCH REPAIRING—Another course offered at the Nova Scotia Institute of Technology and an excellent one for rehabilitation cases is watch repairing. Here an amputee is busily repairing a timepiece in one of the modern classrooms.



OUTSTANDING REHABILITATION CASE—This young chap, a victim of cerebral palsy, possesses a remarkable talent for the operation of the gestetner. Taking a commercial course he can also type, with one finger, more than 36 words a minute.

Post-Graduate Course in Rehabilitation Nursing

Notice has been received of a special course in Rehabilitation Nursing being offered by the Rehabilitation Institute of Montreal for graduate nurses. The principles and philosophy presented can be applied in various work situations: direct patient care; teaching and/or supervising students, professional or non professional personnel; public health services and family teaching.

Special emphasis will be placed on a specific disability each week. General topics will be:

- Cerebral Vascular Accidents and other Neurological Problems;
- Spinal Cord Injuries and Related Disabilities;
- Amputation, Arthritis and miscellaneous diseases;

General Rehabilitation Services and Pediatric problems.

The course will be offered alternately in French and English. For further information apply to Director of Nursing, Rehabilitation Institute of Montreal, 6300 Darlington Ave., Montreal 26, P.Q.

Second Training Course in Rehabilitation

The Canadian Rehabilitation Council for the Disabled has announced that a second training course in rehabilitation will be held this year from May 31 to June 18 at the Manitoba Rehabilitation Hospital in Winnipeg with co-operation of the Department of Extension and Adult Education of the University of Manitoba and the Federal-Provincial Vocational Rehabilitation Program.

Conference Report

NATIONAL REHABILITATION ASSOCIATION 1964 CONFERENCE

November 9-11 Philadelphia, Pa.

Over 1500 persons registered for the 1964 Conference of the National Rehabilitation Association in Philadelphia. The NRA is a private, non-profit corporation dedicated to the rehabilitation of all handicapped persons. Some long-standing members recalled the first meeting of the Association forty years ago at which eighteen persons were present. Today its membership is over 1,900 with 54 state and local chapters. The roster includes professional workers in all areas of rehabilitation—administrators, physicians, nurses, psychologists, counsellors, social workers, therapists—and thousands of other persons interested in helping the disabled to help themselves. The annual conference affords a wide interchange of views and information concerning latest developments in meeting the problems of rehabilitation.

Poverty and Rehabilitation

The keynote address, "National Poverty and National Rehabilitation", given by Dr. Ben H. Bagdikian forcefully drew the attention of delegates to the contribution that rehabilitation can make towards a solution of this problem.

Dr. Bagdikian emphasized that the important point in the "war on poverty" was not to disperse the symptoms but to attack the process which produces poverty. The degree of separation of the poor from the rest of American society is increasing. The children of the poor lack the basic white-collar, pencil and paper cultural tools with which to begin their learning. They may resemble their parents and grandparents but they no longer resemble their contemporaries. The poor are surrounded by others who have lost touch with the working world. The "tips" to new jobs are known to those already at work and are given to relatives, friends and colleagues. When the Packard Motor Co. released 4,000 men, 75 per

cent found new jobs through the intercession of friends. The poor are cut off from such useful contact with the larger society. Many of them were once competent in some endeavour, but rapid change in the environment has made many competent people obsolete. The same process is capable of making any of our children poor. Dr. Bagdikian said that we know many of the techniques which have proved successful in returning individuals to the active society and we must apply them to the condition of poverty or none of us is safe.

Advances in Research

A general session on research advances, presided over by Miss Mary Switzer, Commissioner of the U.S. Vocational Rehabilitation Administration, provided a fascinating glimpse into future developments in prosthetic appliances. At Highland View Hospital in Cleveland, Dr. Charles Long is investigating the use of computers and their associated systems for directing the movements of powered arm braces for the paralyzed. In a film taken at the hospital, a young quadriplegic was shown as the research subject. The computer was programmed for the variety of arm motions and positions required in eating, shaving and other functions. In the demonstration, the young man's arms and hands were moved by powered braces, directed by the computer so that he could eat a meal at a table. Control was provided by the subject himself by means of electrodes temporarily attached to his eyebrow muscles and wired to the power system. While, obviously, this somewhat cumbersome arrangement is intended for research purposes only, it is hoped that the experiments will provide information which will have practical application for developing simpler systems in the future that could be used at home.

Advances in design of artificial limbs were described by Dr. Sam Colachis who showed a film of the work being done in prosthetic research by the University of California, Los Angeles. Excellent results have been obtained with limb sockets which come into total and direct contact with the skin. Artificial muscles powered by small carbon dioxide cylinders were worn by some amputees in the film to replace the muscles lost. Sometimes these artificial muscles were used to bend the elbow of an artificial arm. Changes in design of artificial legs enabled the amputees' weight to be taken off sensitive areas of a stump.

Automation came into the picture again in some of the psychological and vocational research. Much of a psychologist's time is spent in writing down the test results of his clients. Now some of this recording can be done by the data processing machines. It was advocated in the discussions that there should be closer collaboration between rehabilitation researchers and the universities or corporations, particularly in the use of the computer resources which these organizations have available.

Automation and Employment

A top flight session was held on automation and its effects on employment. The panel was composed of Dr. Charles Bowen, Manager of Educational Projects for I.B.M.; Dr. William Bomberg, Professor of Industry, University of Pennsylvania; Dr. Emanuel Mesthene, Executive Director of Harvard's Technology and Space Program and Dr. Walter Neff, Director of Research for the Institute for Crippled and Disabled in New York. It should be noted here that NRA has a subcommittee on automation which works very closely with the office of Automation and Manpower Training of the U.S. Department of Labor. This committee plans to issue a series of guides on automation for the use of local NRA chapters in running study sessions and similar activities.

Dr. Bowen said that automation created new kinds of jobs and therefore a real challenge to society was in educating and training people to meet these changes. Rehabilitation offered a unique approach to the whole problem of relating the individual to employment, which could apply throughout the whole economy.

Other panelists said that the new theories about how people learn must be applied on a wider scale. There should be a "tailored approach" to the employment problems of all those persons made redundant by technological change, similar to the successful approach developed in the field of vocational rehabilitation of the handicapped over the years.

Dr. Neff said that rehabilitation workshops should be "vestibules to the open labour market" and not "refuges." We must be sure that workshops are not training people for work situations which are becoming extinct, he warned.

New Programs

Some unease was expressed that vocational rehabilitation seemed to be on the outside looking in at the newer programs now being developed in America to deal with the problems of chronic unemployment and poverty. The opinion was expressed several times that the particular expertise of rehabilitation, developed over twenty to thirty years, was being under-utilized by these newer programs.

Some of these programs were described in the closing session of the conference, which was presided over by the Hon. William P. Young, Secretary of Labour and Industry for the Commonwealth of Pennsylvania. Programs of "Mobilization for Youth" (part of the Manpower Mobilization and Training Program of the U.S. Department of Labor) aims to assist young job seekers aged 16 to 21. Many of these are school drop-outs and suffer three times the general unemployment rate. They show little motivation to hold a job.

The particular project described was in New York City. Some of the techniques used to increase employability of these youths are prevocational training, academic upgrading, training-on-the-job, counselling, psychological testing, social casework and legal aid. Ordinary vocational training in a technical school is usually too demanding for these youngsters. The pre-vocational or work experience training period is a maximum of six months and the average is four. Thirteen kinds of work are performed, much of it service work benefiting other poor New Yorkers. There is a woodshop which makes furniture to sell to non-profit groups. The quarters of social agencies are

renovated. The training project also runs a gas station and a restaurant, provides kitchen and ward staff to hospitals, runs a sewing shop and provides clerical help to offices of non-profit organizations.

In two years, 400 young people have gone through the project and most have been placed in regular employment.

Other programs described were directed at helping the hard-core unemployed, juvenile delinquents and homeless men. Many of the resources needed for these people to become part

of working society are presently used in the vocational rehabilitation program. Research is now being carried on to determine the best way of extending these vocational rehabilitation techniques to other disadvantaged groups.

Opportunity for delegates with particular interests to come together was afforded through luncheon meetings, including those of the International Society for Rehabilitation of the Disabled, the President's Committee on Employment of the Handicapped and Goodwill Industries Ltd.

THE VITAL ROLE EDUCATION PLAYS IN REHABILITATION

by Sheila Walsh, Grade XI

Holy Heart of Mary Regional High School,
St. John's, Newfoundland

The disabled must be outfitted for life, given the opportunity to enjoy the benefits of modern society, and armoured to meet the challenges of twentieth century living. The concept of rehabilitation must, in a mechanized, fast-moving, modern world be wide in its scope, purposeful in its aim, and realistic in its outlook. And the vital, necessary role that education must, and does play, if rehabilitation is to become a definite fact, and not just another nebulous theory, should not be underemphasized.

Rehabilitation has been defined as "a continuous process by which disabled persons are transferred from the state of being incapable under full medical care, to the state of being producers and earners." Can we put a man on crutches, give him an artificial arm or plant him in a wheel chair and say we have rehabilitated him? Can we cure or lessen his physical disabilities, neglecting those of his mind and spirit, and still say we have achieved our aim? The whole idea is to return to society a man disabled in body but unbroken in spirit. Unless this is so the goal of rehabilitation is useless and profitless—both to the individual and to society as a whole.

Despite despair and anxiety, physical wounds heal, and it is then that the disabled person must consider his future—a future which may be very different from his previous life. For the person severely disabled, manual labour is usually impossible; for the less severely disabled a more advanced education is desirable if a comfortable economic life is to be maintained. How can the disabled hope to compete in the impersonal business world, if besides his physical limitations, he is shackled with the chains of a poor or incomplete education? Education is the only tool available for the disabled to aid him in the work-a-day world; it will secure him a comfortable job with economic independence; it will enable him to take his place among his robust, full-limbed, normal comrades. In a physical sense he may be limited, but through education he can develop talents and skills of which he probably has been completely unaware. An education can bring the same satisfaction and rewards found formerly in manual labour. Through education uneducated disabled persons can develop their intellectual powers, and the ordinary educated person may go on to intellectual feats previously not considered.

Just because a man is disabled—has lost an arm, a leg or his sight—does not mean he has become any less a man, and being a man he will cherish and welcome the responsibilities and rewards of a real job. The person who is not physically ill usually is not content to spend the rest of his life living on a pension and wallowing in self-pity. Most people would prefer to earn their own way in life, not dependent on the charity of others, no matter how well-intentioned it may be. A man does not feel that he is a real man unless he can stand on his own two feet, whether they be flesh and bones or steel and wood. Education will permit a man to get a respectable job, which is the best challenge to goad a man to forget how badly off he is and begin to consider again his potential. If the disabled man were a plant he would be contented to sit back and lap up the charity doled out by his more favoured neighbours, but a man cannot respect himself if he has to lie back on his disability. Education must be his crutch, enabling him to stand erect and face his duty to society as a full-fledged, self-supporting and competent member.

All education is worthwhile; it is always an asset and to the disabled it is doubly so. The man who cannot use his hands must be taught to use his brain. The disabled person, through education, is provided with the opportunity to feel that he is equipped to make a meaningful and satisfying contribution to society. Can we deny him this worthy aspiration? The aims of education are manifold—the acquisition of knowledge, intellectual discipline, preparation for citizenship, character development, and many others. These aims are necessary in the life of every man, and especially so in the life of the disabled person. The father of a disabled child has said, “We see our children being denied their basic rights. The pursuit of happiness should not be limited to the strong and able—it should apply to everyone.” Education is requisite for the happiness and well-being of the disabled; how can we neglect or minimize it?

Education for the disabled is practical as well as invigorating. Paul Monroe from “A Brief Course in the History of Education” says “education is not an artificial procedure by which one acquires a knowledge of the forms of language

and literature or of formal knowledge of any sort but it is an unfolding of capacities implanted in human nature.” The fact that the disabled shut much of normal life and existence from their lives frequently enables them to focus their attention more effectively upon some particular segment. Often in a hospital for the disabled there are patients skilled in particular fields—some are avid naturalists, many are mechanically inclined, some have extra sensory perception. By using these keen faculties through a well thought out education these natural faculties and skills may be developed and increased. Some individuals of low intelligence may learn simple trades better than those of a higher intelligence quotient. Many of the mentally disabled may be educated in simple mechanical manipulations better than the average normal individual. Thus the education of the disabled is usually very successful, as having shut out much normal activity and experience, they are better able to focus their attention and skill upon a few outlets of deep satisfaction. The educability of the disabled has been proven in the lives of thousands of persons who have overcome physical handicaps through a good education and have taken their places as co-partners in society. Manual labourers, having lost the use of their arms, have gone on to higher education and become teachers and lawyers; many of the blind, because of their extremely acute hearing, have become expert piano tuners; many disabled, formerly considered bed-ridden and helpless, have been educated in simple skills and have gone on to lead useful and productive lives. The rewarding results of education for the disabled can be seen in the fact that of 6,308 seriously disabled persons, who with their dependents, were costing society annually \$4,500,000 to support, having been educated and now usefully employed, these same disabled Canadians are now earning over eleven million dollars each year.

The late President Kennedy has shown to the world his own evaluation of a sound education, both for normal men and women and for those who are disabled. In one of his best-remembered speeches he has said “Education is both the foundation and the unifying force of our democratic way of life—it is the mainspring of our economic and social progress—it is the highest expression of achievement in our society”.

(Continued from Page 10)

Whenever x-ray examination is considered necessary by the attending doctor, the Board requires that all such films be forwarded, within a five-day period, as a record of diagnosis, treatment and progress. The Board is thus in an excellent position to follow the progress of any particular case and to judge the adequacy of treatment. At the present time between 600-700 x-rays per day are sent to our Head Office where they are screened, photographed and returned. Serious cases are reviewed with our consultant radiologist and orthopaedic surgeons. The co-operation and enthusiasm of the medical profession for our plan has contributed to a large extent to any success we may have gained in our attempt for early rehabilitation through a definitive medical programme.

At the Toronto suburb of Downsview, the Ontario Board operates a Hospital and Rehabilitation Centre. A substantial Centre on a site of 65 acres, the buildings cover some 14 acres and were built and equipped at a cost of approximately \$6,000,000.00. It is staffed by some 15 full-time doctors, 3 part-time doctors, 24 physical therapists, 25 occupational therapists and 13 remedial gymnasts, who form part of the total staff of some 300. The cost per patient per day is: in-patient \$16.25 and day patient \$11.25, including the cost of amortization of the capital cost of the total property. Regarding our Vocational Rehabilitation Department, teamwork is the keynote of our programme. The Rehabilitation Officers at the Hospital and Rehabilitation Centre work in close co-operation with our Claims and Medical Departments.

Financial Benefits

Financial benefits are of considerable importance in any vocational rehabilitation programme. A seriously injured workman's first concern is not necessarily the diagnosis of his disability, nor even the prognosis beyond the prospect of recovery; it is usually "What can I do in the future?"—"How can I support my wife and children?"—"Will I be able to return to work again?" This provides a perfect groundwork for a neurosis.

The workman must not be allowed to be concerned about financial hardship during his treatment period nor to have fears and forebodings for the future.

Financial benefits in Ontario provide for a payment of 75% of the workmen's earnings. The present yearly rate on which compensation benefits are paid is \$6,000.00. This provides a workman with a maximum weekly benefit of \$86.54, while he is totally disabled as a result of a compensable accident. When they recover to the degree that return to modified work is possible, this amount will be reduced for a temporary period.

Payments for a permanent disability as the result of the compensable injury are made for life and are paid regardless of what the injured workman may do. Minimal awards are paid on a lump sum basis. Pensions are paid to the workman with residual disability, as the result of the compensable injury, on a monthly basis when the award produces a sum which provides a pension of \$15.00 per month or more. It is the workman's privilege to return to his former job, or to any other job, to make the same money, or to make more or less money, or to sit in his armchair and not work at all, without any change in his award.

This provision of our Act is of great importance to our Rehabilitation Officers. We are able to inform the injured workman as soon after injury as possible just what his rights and privileges are under the Act. This enables us to review the individual's problems and, in a more realistic and concrete manner, plan with him for his future. The assistance we are prepared to extend depends on the extent and nature of the individual's problem.

Vocational Rehabilitation

Earlier I stated that the injured workman's main concern is his future. Therefore, should not we as workers in the rehabilitation field, follow the workman's lead and likewise think of his future. This is what we have done in Ontario. Compensation must be paid according to the Act; in this we have no option. Medical aid is provided

as we would wish to have it provided for ourselves, but surely that is not all we should do for the permanently injured workman. Remember the social consequences in these cases are always serious. The injured workman, if left to his own resources, may see only the industrial "scrap-heap" as his future, and penury for his wife and family.

In our experience, we have found the vast majority of injured workmen desire only to return to their old or modified jobs with their former employers. This is readily understandable: a workman may well have certain seniority rights or fringe benefits which he obviously wishes to protect. Further, we find a lack of education, inability to learn new skills, language difficulties and age, often make training or retraining difficult, if not impossible. In fact, there may be inherent in such a process, certain additional threats to the individual concerned. As far as possible, we endeavour to see the injured workman physically restored to the degree he can return to his former field of employment. This occurs in possibly a good 80% of the cases we service.

Ontario is a large province and to service it, our Board employs 31 Rehabilitation Officers; these with ancillary and secretarial staff make up a Departmental strength of 51. Our Rehabilitation Officers give effective service to all industrial areas in the province. With us, a Rehabilitation Officer undertakes to service all cases arising in the geographic area for which he is responsible.

We do not feel that any Rehabilitation Officer is in himself competent to handle adequately all vocational rehabilitation problems arising in his area, however well trained or experienced he may be. Some cases may require the combined resources or skills of several services or agencies. It is the responsibility of the Rehabilitation Officer to act, if you like, as a co-ordinator and to utilize all possible resources to plan effectively and execute the best rehabilitation measures possible for the disabled workman compatible with his abilities and disabilities.

The resources of the Workmen's Compensation Board of Ontario are adequate for the great majority of the industrially disabled. Certain groups such as the blind and the paraplegics

require a specialized service which is available in an adequate way in the province. We, of course, would not be justified in duplicating any such service where the numbers are small—this would not be economical. In these particular cases, we do have an effective liaison with the responsible agencies and would participate in the evaluation and planning for the individual. We would also assume the responsibility for the financial costs of any approved programme.

In an organization such as ours, the vocational rehabilitation cases are, of necessity, referred to the Vocational Rehabilitation Department. In the main, the referrals are made by our Medical and Claims Departments. On the other hand, our Board is active in the field of education as it pertains to the compensation process. Seminars are regularly held for management and labour groups; speakers are also provided for meetings for many different associations. The medical profession is also well informed through area and regional meetings as well as in medical publications. These and others are encouraged to communicate directly with the Vocational Rehabilitation Department and to acquaint the Department with any particular vocational rehabilitation problem at any time. We will then evaluate the problem and determine what, if anything, should be done.

For injured workmen admitted to our Hospital and Rehabilitation Centre, we do our own screening of vocational problems. The number admitted in 1963 was 4,495. The Rehabilitation Officer in consultation with the Medical Officer will determine what modification in the job content will be necessary as a result of the injury sustained. Many injured workmen do not come to our Hospital and Rehabilitation Centre because adequate treatment and evaluation resources for them are available in their own districts. Vocational problems arising with this group are also the responsibility of our Rehabilitation Officer covering that area.

In determining the course of action in any particular referral, the Rehabilitation Officer has available to him the complete medical evaluation,

physical and work assessment tests. When necessary a psychological or vocational assessment by our psychological staff may be obtained. Psychological assessment is not routine at our Centre. It is a consultative service available on request.

The Rehabilitation Officer as co-ordinator of vocational rehabilitation services fully recognizes that his part may be small compared with those responsible for treatment. Nevertheless, his part is of vital importance, and his participation increases as recovery progresses and the vocational future becomes imminent. The rendering of service is a process suited to the needs of the individual through the teamwork approach because all efforts must be adapted to meet his peculiar needs. The many and varied factors that must be considered are not susceptible to correct measurements. Individuals cannot be sorted and classified into types and treated according to prearranged plans. The most completely organized service will fail if it does not provide the ready means of adaptation to individual needs and the fullest understanding of human behaviour.

There is no legal obligation in Ontario for an employer to rehire an injured workman. There is, however, a moral responsibility which most employers accept. As would be expected, there are occasions when an employer's operations may be such that he cannot return the injured workman to suitable employment. This situation arises largely in heavy industry, mining, bushwork and in small plants. Equally unfortunate is the fact that these operations are often located in areas where lighter work is not obtainable owing to lack of secondary and light industry.

Where it is not practical or possible for a workman to return to his former work, a job requiring essentially the same skills is preferable. To provide a suitable position, some adjustment may have to be made to machinery or modification of the job effected. It is surprising how many jobs an injured workman may be fitted for with some adjustment, requiring minimal, or no additional training. In Ontario, organized labour are giving this aspect consideration in the writing of new agreements.

Now and again we have a well-meaning employer come to us on behalf of an injured workman and suggest he would like to affect a change of duty. In such circumstances, it is only fair to the injured workman to determine whether a change is really necessary or desirable; after all the workman may have no desire to change. Whether a change should or should not be made can be determined only after full evaluation.

If training for a new job is indicated, the workman will be assisted during this training period. If vocational training is advisable, any recognized agency whose services are indicated and desirable may be used. All such training expenses are paid by the Board. If the workman's former employer is not able to place him satisfactorily on completion of treatment and training, he will be assisted in finding suitable employment elsewhere. A programme such as ours cannot be developed overnight.

In fact, in the year 1921, a report issued by a select committee of the Ontario Legislature outlined a rehabilitation plan and continued, "Objection can be urged, it is true, against such a plan, that it is academic in scope, paternalistic in conception, and socialistic in execution, that men will not submit, that employers will not provide employment, that trade unions will object, that it costs too much, that it is not practical".

"Whether it be paternalistic, idealistic, socialistic or academic is beside the point. The fundamental fact is that there is a problem; that the problem requires solution; that the problem can be solved and solved only by action."

That action was initiated in Ontario some 40 years ago and has been developed to the point where we have a rehabilitation programme coveted by many. Success, of course, cannot be wholly attributed to our legislation. I would be remiss if I did not add that our competent and dedicated staff have perhaps played a more important part than our legislation. However, with our excellent staff we perhaps can do little else but succeed.

Vocational rehabilitation is an investment in our future; it should be conducted on a scale commensurate with the need and should be worthy of our great country.

THE OLDER WORKER IN A CHANGING EMPLOYMENT ENVIRONMENT

Summary of the introductory address to the International Management Seminar on Job Re-design and Occupational Training for Older Workers, Organization for Economic Co-operation and Development, delivered by Ian Campbell, National Co-ordinator, Civilian Rehabilitation Branch, September 30, 1964 in London, England.

Until comparatively recent times, changes that affected the social and economic life of man tended to be gradual. Now, industrialization, urbanization and rapidly changing technology have greatly increased the rate of change. At the same time our philosophy has changed from "survival of the fittest" through the "custodial" to the nobler concept that all individuals should have an opportunity to be self-sufficient, as envisaged in the Universal Declaration of Human Rights in 1948.

As we consider the problems of the older worker, we must retain this concept, and endeavour to use our new knowledge for the betterment of all mankind.

In the face of enlightened concepts, advances in knowledge, and when the material needs of man are far from satisfied, why should he have the problem of underemployment of the older worker?

One reason is that, in industrialized nations, changes have taken place in the age structure of populations. Medical science has improved the health and increased the life span. In addition, fertility and migration, with the political, economic and social factors which influence them, have resulted in an increasing proportion of older people including, of course, older members of the labour force. This change has also been affected by the re-entry of married women into the labour force and the later entry of young people due to the need for more intensive preparation.

How is an older worker identified? It was generally agreed at the OECD Seminar on Age and Employment at Stockholm in 1962 that the "older worker" be considered as someone in the second half of working life who is approximately 40

years of age or older. In Canada we refine this a little to include anyone who, because of advancing age, encounters difficulty in obtaining or retaining employment.

Rapid changes in the work pattern have profoundly affected the prospects of this group. There has been an increase in white collar and service occupations, a decline in the demand for unskilled labour, a severe decline in primary occupations such as agriculture and fishing. The working day, week and year have been reduced; new technology demands higher levels of education and training and a greater need for flexibility and adaptability on the part of the worker.

Rapid changes in industrial patterns present problems of adaptability for all members of society. Solving these problems may be more difficult for the older person, whose skills and experience may be obsolescent, and whose education may be inadequate for the new job. His status in the community is largely determined by his type of occupation and his level of earnings. If these are lowered by unemployment or downgrading a detrimental social effect results. Then too, there is the effect of long unemployment which results in the man becoming psychologically unemployable without rehabilitation.

It is economically impossible to improve the standard of living if increasing numbers of older persons are rejected from the productive section of society. Their capacity to consume, to produce and to share taxation is lowered, throwing a further burden on younger persons. If more young people remain at educational institutions for longer periods, this adds to the load of the productive section. This trend could result in the lowering of the national standard of living unless

it is offset by a corresponding increase in productivity by those working.

In areas of labour surplus the main concern has been to educate employers and the public to recognize the capabilities of the older worker: in areas of labour shortage the emphasis has been to encourage them to remain in the labour force and to adapt themselves to their new jobs.

In both areas, however, there is need for education and retraining throughout the lifetime of the worker, and the workers must understand that few of them will continue in one occupation for a lifetime. To the younger worker, usually better educated and with more up-to-date skills, change should not be too difficult, but the older worker with his generally lower education and skills, habits, ideas and customs developed over some 20 years will require help in the form of counselling, assessment and understanding of his situation. Employers and the public also need to be made aware of the peculiar situation of the older worker.

In seeking information on automation it became obvious that the experts are in disagreement as to its ultimate effects. It is obvious that change is inevitable and that, both in people and in nations, flexibility and a capacity to adjust thinking and customs rapidly will be required.

To emphasize the areas of common interest to all participants at the Stockholm meeting in 1962 it was generally agreed that:

1. A new and growing problem exists concerning age and employment.

2. The present nature of the problem is a complex result of many things—population structure and trends, labour market economy, rate of technological change and social and educational pattern.

3. Three specific problems can be identified and, although related, should be given separate treatment:

- (a) the effect of increases in the rate of technological change in men and women past the mid-point of their working lives;
- (b) the transitional phase around the usual pensionable age; and
- (c) full retirement.

4. Semi-skilled and unskilled persons face greater problems than skilled or highly trained persons.

5. Chronological age is an unsatisfactory measure of a worker's capabilities.

6. The communication of facts obtained by research workers to the users—government, management and trade unions—does not appear to have been successful to date.

Too little of the excellent work of ergonomists and researchers has been produced in form and language readily understood at the plant level.

Growing international concern with the problems of aging was stimulated by the ILO's pronouncement in 1938, and is continuing.

The OECD has increased the practical understanding of the problem and by its organized studies has indicated various approaches which could lead to the practical application of methods which may be used at the local level.

It is significant that in areas of low unemployment, for instance Western Europe and Great Britain, research has tended to focus on job re-design and special methods for retraining older workers.

In the broad field, studies have been undertaken concerning the characteristics of older workers, attitudes towards aging in industry, new concepts of placement methods and services, aging and the semi-skilled, the physical capacity of older workers, physiological and psychological measures, and many other subjects.

It is pointed out in several of these studies that frequently solutions can best be worked out by the individual firm. It is here that modification and job re-design can be studied, and that the understanding attitude of organized labour and management can influence constructive action.

The tendency, especially in Europe, to extend the scope of vocational rehabilitation services to include persons handicapped in other ways such as by age, attitudes, lack of education, etc., can be of great value, especially where individual counselling, assessment and restorative services, training and placement are included. North American opinion is beginning to demand similar services.

In areas of labour surplus research has been directed to substantiating the fact that the older

worker is a good worker; that hiring, retention and promotion should depend upon ability rather than age. Consequently research has covered such subjects as productivity, absenteeism, accident rates, labour turnover, learning ability, and the effect of pension plans. In general these studies have indicated that the older worker is a valuable employee.

Technological change makes certain demands on the older segment of the labour force. If they are to be used effectively their jobs must be designed in a way that will not place impossible demands on their physical capacity. At the same time the designing of these jobs must meet the requirements of production. This is a challenge to the ergonomists, who must show those who can apply their principles how to take full advantage of the latent potential in the labour force and that the resultant economic growth and increased production justifies the cost of re-designing jobs.

In summary, we see that the utilization of older workers in the labour force is influenced by:

1. the increasing proportion of older people;
2. the changes in work patterns resulting in rapid advances in technology;
3. the increasing redundancy of traditional skills and occupations;
4. the lower levels of education among older workers;
5. the adjustment difficulties of older persons;
6. misconceptions about the capabilities of older workers.

All the efforts that have been or will be made in seeking solutions to these problems will be ineffective unless jobs are designed and re-designed in keeping with the capabilities of a work force that will contain an ever-increasing proportion of older workers.

TENTH WORLD CONGRESS

*International Society
for Rehabilitation of the Disabled*

WIESBADEN, GERMANY

11th—17th September, 1966

THEME:

*"The Industrial Society and Rehabilitation:
Problems and Solutions"*

Sectional meetings on: research; cerebral palsy; arthritis; vocational rehabilitation; spinal cord injury; leprosy; rehabilitation; special education; prosthetics; speech and hearing; social aspects of rehabilitation; the use of volunteers.

EXHIBITIONS SEMINARS FILMS
INTERNATIONAL PROSTHETICS COURSE

PLAN NOW TO ATTEND

News and Events

C. A. Pippy Awards

Last year's C. A. Pippy awards were presented during the annual meeting of the Rehabilitation Council of Newfoundland, November 30, 1964. These awards are presented annually to the handicapped man and woman of the province who have triumphed over disability and are examples to others of what can be achieved.

Walter James Ryan of Bonavista, one of the winners, suffered an attack of polio when he was two years of age. It left him with both legs contracted and paralysed, unable to walk. Nevertheless he managed to get to school sometimes carried or pulled on a sled. When he was 12 years of age he was given a pair of crutches made for him by a friendly neighbour and for the next 25 years he travelled on crutches. He finished high school in the outport and then went to work in an office in Gander followed by a period as a taxi driver. In 1959 he went back to office employment at Bonavista Cold Storage. The continued use of crutches however, brought about a nerve involvement in his arms so in 1963 he entered General Hospital and after three operations and many months in plaster he is now back at work, walking with braces and using a cane for support on rough ground.

"With a cheerful disposition, by grit and determination Walter James Ryan has come a long way" says Dr. J. W. Heath of Bonavista who nominated Mr. Ryan for the award.

The other winner was Kathleen Brown from Englee who has had cerebral palsy from birth. A considerable amount of her schooling was obtained during 3 years at Sunshine Camp Children's Rehabilitation Centre where she was under almost continuous treatment including some surgery. She boarded in St. John to complete her schooling. Then through the Federal-Provincial Vocational Rehabilitation Program a commercial course was arranged for her. In spite of her difficulties due to spasticity she completed this course successfully. She gained experience working for the Society for Crippled Children and Adults. About a year and a half ago she obtained a position as secretary to Dr. John Coyle. In sponsoring her

for this award, Dr. Coyle said "Kathleen is a self supporting person, always cheerful, well adjusted to her disability and has shown through sheer perseverance and determination and despite many setbacks, a handicapped person can achieve total independence."

Reader's Digest Rehabilitation Award

During the annual meeting of the Canadian Rehabilitation Council for the Disabled held in Toronto in October, A. J. Conduit, vice-president of the Reader's Digest Association (Canada) Limited, presented the second annual Reader's Digest Rehabilitation Award to the Sunshine Camp Children's Rehabilitation Centre of Newfoundland. R. A. Frost, President of the Newfoundland Society for Care of Crippled Children and Adults accepted the award on behalf of the Centre. Mr. Frost told the audience that the centre was, at that time, in the process of moving from the old Camp site to much larger and more suitable quarters in what had been the high school building of the Pepperrell Air Force Base. This building has been newly renovated for this purpose. The new quarters will permit the society to serve a larger number of children in both its in-patient and out-patient services.

Co-ordinator Appointed in Newfoundland

Honourable Dr. James McGrath, Minister of Health in Newfoundland, has announced the appointment of Stanley F. Cullen as Provincial Co-ordinator of Rehabilitation.

Mr. Cullen brings to his new post the benefit of 13 years' experience in rehabilitation with the Newfoundland Tuberculosis Association. As Supervisor of Rehabilitation at the West Coast Sanatorium, Corner Brook, he has co-operated with the Department of Health in planning rehabilitation for persons with handicaps other than tuberculosis. Mr. Cullen previously worked for the Newfoundland Department of Natural Resources but became interested in the rehabilitation field following a two-year period as a patient in the St. John's Sanatorium.

In his new post, Mr. Cullen is responsible for the co-ordination of all provincial rehabilitation services for the handicapped.

Handicapped are Good Workers Says Manager of Winnipeg Firm

Six handicapped clients of the Society for Crippled Children and Adults of Manitoba have been added to the staff of Allied Farm Equipment Ltd., since January 1963.

Employment of the first handicapped person, J. V. Paskewitz, General Manager of the firm, explained, came about through the persistent efforts of a placement officer of the Society. A young man confined to a wheelchair after an attack of polio was given a job with the firm as telex operator and record clerk.

Mr. Paskewitz was so pleased with the young man's work that in the course of a few months he added four more handicapped persons to his staff. The sixth was hired in September 1964. The original five employees are still with the firm. The employees, four men and two women, have been placed in office and stock room positions. The firm maintains a staff of some 40 men and women.

"We find that a handicapped person is not really handicapped when he is matched with a job that fits his capacity," Mr. Paskewitz says. "A handicapped person, he thinks, might actually be more suited to certain types of work that could pay the patience of a mobile employee."

Most of the six handicapped clients were referred to the Society as adults, but one has been provided with rehabilitation services and educational guidance since he was 11 years old. All have been given treatment, vocational training and guidance as required. Some got working experience in the Society's Industrial Workshop for the Handicapped.

The employment of handicapped persons was a straight business proposition, Mr. Paskewitz said. There is no reduction in pay for their services. They are paid in accordance with the type of work they do.

Since the handicapped do not find suitable jobs easily, Mr. Paskewitz felt that they put extra effort into turning out good work. Illness and absenteeism among handicapped employees were low, comparatively speaking, Mr. Paskewitz said.

The firm has found many advantages in hiring staff through the Society for Crippled Children

and Adults, Mr. Paskewitz pointed out. "If we have a job suitable for a handicapped person," he said, "you may be sure that we will offer it to him first."

*("The Society Page" Society for Crippled Children and Adults of Manitoba—
October 15, 1964.)*

Canadian Gift for Gurkha

A blind Gurkha veteran, member of the All India Gurkha Ex-Servicemen's Welfare Association, will soon be in possession of a braille typewriter, gift from the Canadian member associations of the World Veterans Federation.

Capt. F. J. L. Woodcock, WVF Council Member for Canada, himself war-blinded, arranged to present this gift through the WVF on behalf of the Canadian member associations, and with the particular help of the Sir Arthur Pearson Association of War Blinded, who paid the shipping. The Gurkha ex-serviceman, Mr. Bishan Bahadur Rai, lost his sight while in service and is presently engaged in college training.

It was the Gurkha association which drew the attention of the WVF to the ex-serviceman's need for such a typewriter while studying.

*(from "World Veteran" September-
October, 1964.)*

New Film

"ONE STEP AT A TIME"—This film shows the advance that has been made in the designing and fitting of artificial limbs. It is the personal story of an amputee who discards his crutches and learns to walk with confidence on his artificial leg. The film which was made at the Rehabilitation Institute of Montreal by the National Film Board of Canada depicts the professional craftsmanship that goes into the designing of artificial limbs to fit the exact needs of the patient. It also shows how the prosthetist, the physiotherapist and the doctor work as a team to put a man back on his feet. It is a 16 mm., black and white, sound film with a running time of 15 minutes. The film is available through the Canadian Film Institute, 1762 Carling Avenue, Ottawa, Ontario.

New Book Available

*"Job Re-design" by Stephen Griew:
Organization for Economic Co-operation
and Development, 1964;*

Available from the Queen's Printer, Ottawa;
Price \$2.75 prepaid.

In this book, Dr. Griew writes:

"For many years industrial psychologists have recognized two ways of increasing the efficiency of man at work. The first, which is often termed 'fitting the man to the job', involves the selection of workers for jobs which best suit their capacities, attainments and interests, and training them to work efficiently, economically and safely. The second, essentially complementary to the first, involves 'fitting the job to the man' by applying carefully collected data on human performance and capacity to the design of equipment and organisation of work. The object of this second method, which is now usually called *ergonomics*, is to reduce the stresses and strains on the worker to a minimum."

The results of the application of ergonomics to a plant are of advantage to all workers, not only the older ones. By the elimination of stress-causing factors, it becomes possible for a worker to remain at a job for a longer time. In addition, it can make available to older workers jobs not previously considered available to them.

Quite large benefits may often be obtained from making simple and inexpensive modifications, for instance, increasing the level of illumination over a work surface by adding a lamp, by supplying a seat for a machine operator, or by suspending hand tools from the ceiling of the plant.

For the employer, the benefits can be a reduction in the cost of labour turnover including the training of new workers, absences due to sickness, fewer rejections, and increased productivity.

In his book, Dr. Griew summarizes the job features likely to be selected for job re-design for older workers. But this can also contribute to the better utilization of all manpower.

Rehabilitation Offices In Canada

NATIONAL OFFICE

National Co-ordinator,
Civilian Rehabilitation,
Department of Labour,
OTTAWA, Ontario.

PROVINCIAL OFFICES

Provincial Co-ordinator of Rehabilitation,
Department of Health,
Post Office Box 5250,
ST. JOHN'S, Newfoundland.

Deputy Minister,
Department of Welfare and Labour,
CHARLOTTETOWN, Prince Edward Island.

Provincial Rehabilitation Co-ordinator,
Department of Public Health,
Post Office Box 488,
HALIFAX, Nova Scotia.

Director and Co-ordinator of Rehabilitation,
Department of Health,
FREDERICTON, New Brunswick.

Physically Handicapped Division,
Department of Youth,
9175 St. Hubert Street,
MONTREAL 11, Quebec.

Provincial Co-ordinator of Vocational Rehabilitation,
Department of Public Welfare,
85 Eglinton Avenue East,
TORONTO 12, Ontario.

Provincial Co-ordinator of Rehabilitation Services,
Department of Health,
Kennedy & York,
WINNIPEG 1, Manitoba.

Provincial Co-ordinator of Rehabilitation,
Health and Welfare Building,
REGINA, Saskatchewan.

Provincial Co-ordinator of Rehabilitation,
Department of Public Welfare,
101 Street and Jasper Avenue,
EDMONTON, Alberta.

Rehabilitation Co-ordinator,
Department of Health Service and Hospital Insurance,
828 West 10th Avenue,
VANCOUVER 9, British Columbia.

SUMMER

PERIODICALS READING ROOM
(Humanities and Social Sciences)

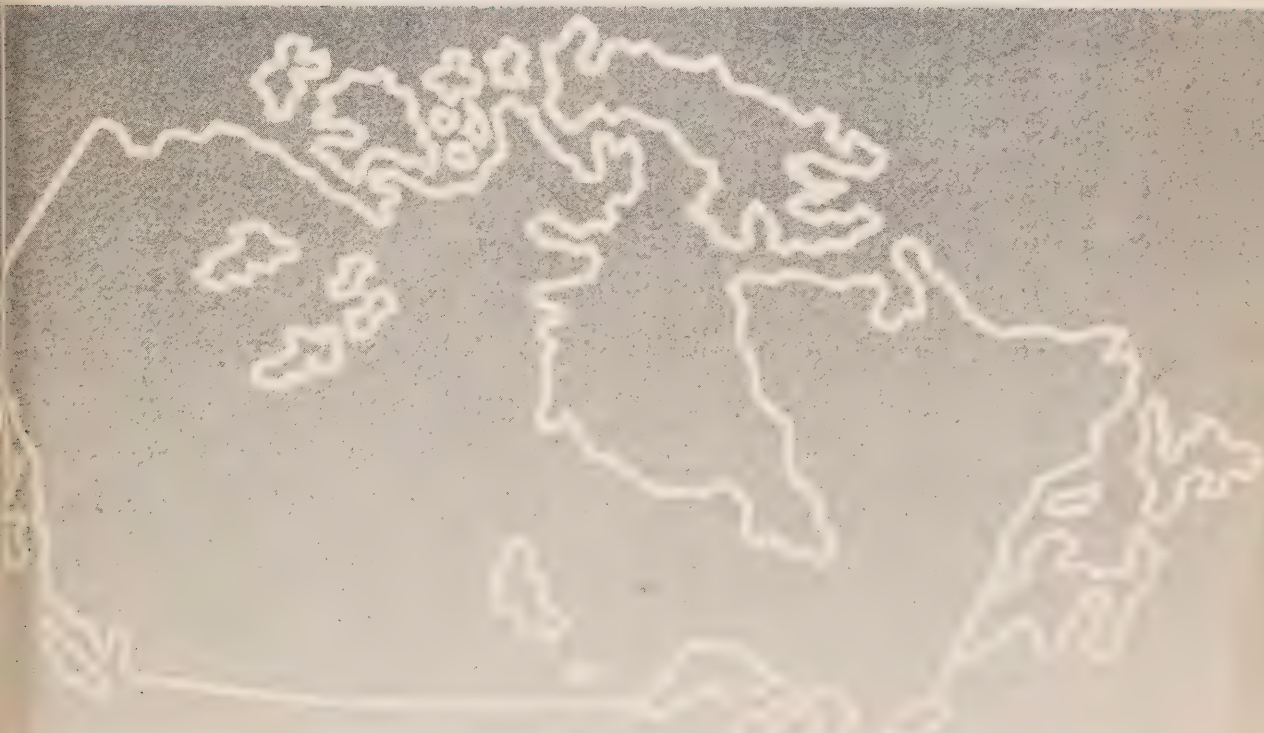
DISPLAY

1965

LATEST ISSUE
USE IN READING
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Rehabilitation IN CANADA



Published in the interests of Canada's Disabled by ...

CIVILIAN REHABILITATION

Department of Labour Canada

ISSUE No. 11

*"I believe in ability; in an entire orientation
toward the handicapped that stresses not what is wrong with them
but what is right with them; that emphasizes not disability
but ability; that faces the fact that the 'can do'
in a man's life exceeds the 'can't do'."*

Harold Russell, Chairman,
President's Committee on Employment of the Handicapped.
Annual Meeting, April 30, 1964.

To Our Readers

From time to time we receive publications describing devices for helping handicapped persons meet the problems of daily living thus enabling them to become more independent.

Some devices are elaborate and costly but many simple, inexpensive home-made aids have proved equally efficient. Disabled persons themselves have shown considerable ingenuity in devising apparatuses to meet their particular problems and frequently relatives or friends have provided practicable suggestions and assistance.

Possibly you know of a device that would help one-armed persons cope with a boiled egg or thread a needle; permit a person with a weak grip to turn a tap, hold a pencil or remove a canister lid; or perhaps you have solved the problem of carrying a parcel while using crutches. If so, we would like to hear of these things, for with your co-operation we hope to establish an "exchange of ideas" column in "Rehabilitation in Canada". Do not hesitate because the device is simple. Be sure to provide a description of it together with diagrams and explanatory notes on its construction and method of use.

The problems of the disabled are many and varied but so are the solutions. Let's share our knowledge and experience !

CONTENTS

Page

- 4 Rehabilitation and Hemophilia
 - 7 Go In and Win
 - 10 Sanatorium Board of Manitoba Sets Up Rehabilitation Research Fund
 - 11 Employment of the Disabled
 - 13 Counselling Handicapped Adolescents
 - 16 Rehabilitation at St. Vincent Hospital
 - 17 New Stump Correction Technique
 - 18 Pre-School Centre for the Deaf
 - 20 Retraining the Middle-Aged
 - 25 The Atkinson Charitable Foundation 1964
 - 26 People and Events
 - 28 New Books
-

This bulletin is prepared by Civilian Rehabilitation, Department of Labour, with the co-operation of the Department of National Health and Welfare, the Department of Veterans Affairs, the National Employment Service and governmental and private agencies interested in the rehabilitation of Canada's disabled.

ROGER DUHAMEL, F.R.S.C.
QUEEN'S PRINTER AND CONTROLLER OF STATIONERY
OTTAWA, 1965



Rehabilitation and Hemophilia

Mr. Frank Schnabel knows the problems of hemophilia from personal experience. He has visited and received treatment at hemophilia treatment and research centres in the United States, Canada, Cuba, England, France and other European countries. He carries on an extensive correspondence with hematologists and hemophiliacs throughout the world.

Mr. Schnabel is President of the Canadian Hemophilia Society and Chairman of the World Federation of Hemophilia. He is a trustee of the National Hemophilia Foundation in New York and of the Quebec Foundation for Polio and Rehabilitation.

Mr. Schnabel is the author of the Readers Digest article "Bearer is a Hemophiliac", and edited the handbook "Hemophilia To-Day".

Born and educated in the United States, Mr. Schnabel has a B.A. in Political Science from the University of Washington and a B.A. in Geography from the University of California.

He is a research analyst for Imperial Trust, Montreal, and is vice-president of both Formula Growth Ltd. and Canabam Ltd. as well as a director of Kativo Chemical Industries Ltd. in Nassau, B.W.I. Mr. Schnabel is also Consul General for Porto Rico in Montreal.

Rehabilitation and hemophilia... is there a contradiction, that is to say, is this defect of the blood outside the context of rehabilitation?

While attending the Eighth World Congress of the I.S.R.D. in New York, I employed most of my time in personal discussions with delegates, particularly those from rehabilitation centres. I talked with specialists from sixteen countries and I asked each one: "Have you encountered hemophilia cases in your centres?" and without exception they answered, "Yes", and followed invariably with the observation... "What a pity nothing can be done". The pity is that these men did not know of the great work being done by Dr. Jordan only one mile away at Lenox Hill Hospital. Hundreds of hemophiliacs have entered Lenox Hill on crutches or in a wheel chair and after prolonged orthopedic treatment, have walked out of the hospital.

I would like to quote from a memorandum on the subject by Dr. Cecil Harris, Medical Consultant, Canadian Hemophilia Society:

"In all but mild cases, arthropathy is the inevitable consequence of haemarthrosis. This leads, if untreated, to limitation of movement at joints and to muscular wasting with consequent disability. This condition, once established is permanent and tends to be progressive. The picture, then, is of life-long orthopedic disability punctuated by acute episodes of hemorrhage. Determined physiotherapy leads to improvement. Ground is usually lost after a hemorrhage and physiotherapy must once again be employed to attain optimal function. An understanding of the problems faced by hemophiliacs makes it clear and beyond dispute that rehabilitation in all its aspects is essential to assist the individual

in his efforts to be self-sufficient rather than a complete burden on the community."

Like cerebral palsy, hemophilia presents a challenge to rehabilitation with a diversity which requires the assistance of many trained people in different disciplines. Only a few Canadian rehabilitation centres have had any experience with hemophilia. Physicians and family, coping with one crisis after another, have had little time left for thinking of the hemophiliac in the broader rehabilitation context.

Another factor has been, until recently, the high fatality during childhood, thus few sufferers survived to an age where rehabilitation services would be required. Now the pendulum is swinging to the other extreme and the problem will explode. Not only must existing rehabilitation facilities be adjusted to help the hemophiliac, but we also need to get the message to the hemophiliac to take advantage of rehabilitation services.

Those of us in the struggle to help the hemophiliac, the Canadian Rehabilitation Council, the Hemophilia Society and the hemophiliac himself, are today confronted with a cruel dilemma. Hemophiliacs are more than just grateful, for they owe their lives to Canadian blood donors. When one owes such a debt, one hesitates to cry out in protest that the program does not realize its full potential. For years, Canada has been in the forefront in the treatment of hemophilia. Five years ago, certain Canadian metropolitan hemophilia centres were envied by hemophiliacs in Europe and the United States. We knew American hemophiliacs who considered moving to Canada. We blew up our bubble, then suddenly it burst in the realization we do not live in the hemophilia millennium.

During the last three years executives of the Canadian Hemophilia Society have visited hemophilia centres in Europe and the United States. We have been exposed to most of the world's famous coagulationists, either in personal discussions or correspondence. In addition, we collected the latest medical literature describing recent breakthroughs in the management of hemophilia.

Thus, we realize the hemophilia hiatus, the widening gap between the advanced program

elsewhere and stagnation in Canada. The reason for the contrast between Europe and Canada is the availability and utilization of a blood fraction which controls the condition more effectively than whole blood or plasma. Scientists have been successful in concentrating for clinical use the clotting agent lacking in the blood of hemophiliacs.

This concentrated human plasma, with increased potency in smaller volume, is especially desirable in children and where undue amounts transfused may lead to overloading of the heart and circulation.

With liberal use of concentrates, European coagulationists are correcting hemophilia to levels near normal. In other words, when under treatment, they prescribe in terms which produce a normal state whereas on this side of the ocean we fall short of this objective because we lack the concentrates. Falling short means pain, and crippling; perhaps death.

In September, 1964, the International Societies of Hematology and Blood Transfusion met in Stockholm. The agenda included a Symposium on the treatment of Coagulation Disorders with 26 participants from eleven different countries. Dr. Rosemary Biggs, Oxford, England, presented the opening review.

Dr. Biggs stated flatly that management of Hemophilia and related disorders require major efforts in clinical attention and in the provision of suitable transfusion material, but that *such efforts were well worthwhile* and, indeed, inescapable from a humanitarian point of view, resulting as they do in lengthening of life, in relief of pain, in lessening crippling deformities and arthropathies, and finally in offsetting the dreadful fears which attend the sufferer every hour of every day.

Within the last few months, we believe that certain Canadian hemophilia youngsters could have been saved, if we had had the concentrate available throughout the country. Small amounts of the concentrate are being produced in Canada but only a few hospitals have been able to obtain it.

In 1962 Sweden produced and administered 2926 units of the Blomback Fraction 10, each

unit equal to 1500 ml. of plasma, and 2700 bottles of fresh frozen plasma, thus in 1962, 52 per cent of all infusions were the concentrate and the percentage has been increasing.

In France, the National Blood Transfusion Centre produces the concentrates and sells it to the hospitals at cost. In the hospitals, 80 per cent of the cost is covered by government insurance plans and the balance by supplementary private plans.

I would like to emphasize the Australian experience. The comparison between Canada and Australia will give us some idea of the feasibility of an ambitious concentrate program for Canada. The Australian population, like the Canadian, is spread across a vast continent. The health plans are similar as the Australian states, like Canadian provinces, exercise considerable autonomy. Both countries have national blood programs and one or two laboratories where blood fractions are produced. More comparisons can be made, but when it comes to the management of hemophilia, the analogies come to an abrupt end.

Since early 1962, the Commonwealth Serum Laboratories, Melbourne, have been producing

Anti Hemophilia Factor, the concentrate, using a method introduced by the Doctors Blomback of Sweden. The concentrate has been used in all the Australian states and with very satisfactory results. There have been no adverse reactions to its use in Australia. Initially supplies of the concentrate were used therapeutically with only a small prophylactic usage. The prophylactic or protective effect of a single dose of concentrate once a month, first explored by the Swedish workers, retards bleeding attacks in severe hemophiliacs. While attending the World Federation meetings in Amsterdam in 1964, the Australian doctors informed me that Australia presently has 80 to 100 hemophiliacs receiving one dose of concentrate a month, prophylactically and requiring about 10,000 blood donors. Australia's Dr. Pitney, during the recent Symposium in Stockholm, stated that *the trend in his country is towards the use of concentrates exclusively.*

Can we afford the concentrate in North America, in the world's two most affluent nations? The real question is . . . can we afford not to have the concentrate? How much does a disabled, dependent person cost the community?

UNESCO Promotes Education of the Handicapped

The General Conference of UNESCO at its Thirteenth Session, October-November, 1964, adopted two resolutions affecting educational programs for the handicapped. Resolution #1292 requested the Director General of UNESCO: 1) "to give increased attention, within the framework of overall educational planning, to the education of handicapped persons by engaging in research and study of this problem; 2) to seek the co-operation of institutions already actively engaged in the education of handicapped persons in order to achieve optimal results in efforts to assist this category; 3) to give due consideration to the problems of handicapped persons in UNESCO-sponsored projects for teacher training and free and compulsory education of (ordinary) children of primary school age, and to the ap-

pointment of a committee with instructions to work out an additional article in the 'International Code of Education' concerning the right to education of the handicapped persons."

Resolution #1211 invites member states to "develop and improve their planning of education, particularly through expansion of planning services for the elaboration and systematic review of short and long-term education plans to meet the requirements of both economic and social development and the full development of the individual, including those who are handicapped, and through the strengthening of administrative services which are required to implement the plans."

To insure the implementation of the resolutions, all organizations for the handicapped are urged to contact their national committees for UNESCO and interpret to them the educational needs of the handicapped.

(*International Rehabilitation Review*, April 1965.)

Go in and Win

BY ELIZABETH NICHOLAS

Many of our readers, whether rehabilitation workers or members of voluntary agencies, will likely find themselves faced with the necessity of addressing public gatherings. If they find this something of an ordeal perhaps they will find help in this article which first appeared in the March 1965 issue of the Almoner, a journal published by the Institute of Medical Social Workers of Great Britain. The writer is a medical social worker and while the content of her speeches may deal with her own work, the principles and rules she has worked out will apply in equal measure to any other subject.

Most people find speaking in public whatever the occasion, something of an ordeal. There are those, and they have both my envy and my admiration, to whom it seems to come naturally, but even they, I am sure, must have started off by feeling nervous. I certainly did and this article is addressed to those who are hesitant, as I once was, about public speaking and not at all sure that the experience will be a rewarding one. I would, however, point out that enjoyable as some of us may come to find speaking in public, there are those who really dread such a task. They may bear it dutifully but with considerable anxiety and I feel that we must accept their reluctance to undertake any commitments of this nature.

I am glad that I made my first effort to speak in front of an audience and to get over my nervousness for I have gradually found that speaking about my work in public has become most enjoyable. I still have moments of apprehension and inadequacy, as I stand facing a sea of expectant faces, but then too, I feel very rewarded as those faces gradually register eager interest and appreciation. Soon I find I lose my

apprehension and hesitancy altogether, so intent am I on my audience's response and on interesting them in my topic. Far from my mind going an awful blank (always, I think, one's most disconcerting fear), I now find as my confidence increases that without a plan I might get carried away by the easy flow of words and run the other danger of boring my audience by spending too much time on a particular part of my talk.

To be successful any task should be planned beforehand in order to eliminate the dangers of "drying up" and "running on". One of the most important aids to planning is to know a certain amount beforehand regarding the composition of one's audience, for dependent upon this are both the content of one's talk and the aims one may wish to achieve. An audience can of course vary from a group of bright young fifth or sixth formers, thinking in terms of careers, to a small group of members of a church or perhaps a political organization who may be particularly interested in the possibilities of voluntary work in hospital. It is helpful when planning a talk for a particular group to meet beforehand with someone who knows that group fairly well and to discuss such details as the type of people in the group, their average age and intelligence, the range of their interests, and what aspects of the subject may be particularly appropriate for them. I usually make a point of enquiring whether anyone in the audience has been recently, or is currently, under hospital treatment particularly for any serious condition, for whilst realism in one's talk is necessary it is tactful to avoid reference to any specially threatening illness. Again it may be better to avoid going into too much detail on certain topics when talking to a younger age group. When planning a

talk for fifth and sixth formers of a large girls' school recently, I was at the time working as maternity almoner and I discussed with the headmistress of the school whether it would be wise to skirt around the problems of the unmarried mother. In fact far from feeling that I should, the headmistress said that she would welcome such reference, both from the viewpoint of giving a realistic picture of my job and as a salutary reminder of the problems that the single mother can encounter.

Another important piece of information needed when planning a talk is the length of time available to the speaker. Usually, I make a point of asking about this both when the talk is first planned and then again just before it takes place. I can then shape my talk in a balanced way. When I have more time at my disposal I may need to prepare more illustrations of my work than for a short talk. I also seek guidance as to how long to set aside for questions at the end of the talk, as this is now usual and often provides the liveliest part of the occasion.

Having ascertained something about the group to whom I am going to speak and the length of time at my disposal I then begin to think about my talk — usually at odd free moments — taking into account in particular what my aims are in addressing the group concerned. Whatever the group I almost invariably wish to stimulate interest in my work and also to give an instructive account of it. Sometime or another some member of the group or a relative or a next door neighbour of theirs is going to need hospital treatment and they may then well need the help of a medical social worker. A referral to a medical social worker may result from my explaining carefully the different aspects of my job.

In addition to these general aims, there is usually a specific goal attached to talking to certain groups. When speaking to a group of 16 to 18-year-old school girls during a series of careers lectures, it is obvious that the aim should be to create interest in the job from the point of view of recruitment. This sort of talk involves a balanced account of our work, the sort of demands it makes upon us, its personal and financial rewards and the conditions of service. On the other hand a group of housewives be-

longing to a local Women's Institute or Church may be particularly interested in voluntary hospital work which they might do, or of possible help which they might give to elderly or disabled neighbours.

Once I am fairly sure of what I am trying to get over I normally prepare a plan in note form under headings. This plan is not a word-for-word script but simply a guide for myself on the points I wish to make. It normally includes some definition of my work at the beginning, possibly a very brief account of our history and then moves logically through the different aspects of our work, building up to a fairly complete picture of the job. Finally, I usually make a particular note to gear the end of my talk to any special interest of the group concerned.

Illustrative material to make one's talk live and have meaning is essential and when planning I make a note of various cases which can be used for this purpose. Hospital life is full of drama and it should be fairly easy for us to capture enough of this to make a talk colourful and absorbing. I usually illustrate each different aspect of our work by quoting from at least one case, possibly two, depending on the time available (for illustrations, whilst they add human interest, can be very time consuming). In my opinion it is better to illustrate by quoting a few details from each of a number of cases rather than to get involved deeply in one or two "big" cases; this avoids the danger of getting lost in detail and so boring one's audience, and also serves to do something towards safeguarding the anonymity of the patient. Remember that once one starts quoting in detail the risk of the case being recognized always increases — particularly in the small community. It is impossible, of course, to be completely cut and dried about this and there will always be one or two cases which one does need to quote more fully. I think that such cases need to be fairly dramatic to hold the audience's attention.

Whilst the chairman is introducing me I attempt to size up my audience visually. I usually try to pick out one particular person sitting towards the back to whom I make a note of addressing my first few remarks. It is easy, when one is nervous, to fall into the trap of looking down at

one's notes when starting to speak and I have found that focusing on someone in this way is effective in combating this danger whilst I gradually gain confidence. Moreover, starting off in this way by speaking as though to one person and then gradually shifting my focus to include other members of the audience individually, as well as a group, helps to produce a fairly informal and relaxed atmosphere in which I am talking to my audience rather than at them. In the first one or two talks that I gave I found it rather difficult to get going. It seemed rather abrupt to plunge in straight away with a definition of what a medical social worker is, and yet I was too nervous to be chatty, so I tried to establish some common ground with my audience. For instance if I was speaking in a particular town or institution I made a reference to the association this had for me and why it particularly pleased me to be invited to speak there. Failing this I would search around for some other ground — after all when speaking to an audience about medical social work it is always possible to refer to their experience of illness and its disruptive effects. Most people have some experience in this area, even if it has not been associated with hospitals. It is easy enough then to go on to expand the theme of the association of illness with problems, and the need for some special worker to try to help the patient with his difficulty. At one careers talk the girls had been given pamphlets on medical social work to read first and I was easily able to use these as a spring board for my talk.

Having achieved some sort of rapport with my audience I have found that I am able to talk fairly fluently from my notes. This is something which has not always been easy. At one time I thought I should be lost without a word-for-word script. Fortunately, however, a well-meaning Welshman took it upon himself to tell me how much more interesting the talk I had just given to his local Rotary Club luncheon would have been had I looked at my notes less and my audience more. This was a sore blow to my ego, but other audiences since have probably had cause to be grateful for his frankness. It is not easy to talk fluently from just a few notes and headings on the first or even the second occasion of public speaking but it is well worth while

trying gradually to school oneself to looking at notes less and less and it is one of those things where practice really does make perfect. I should also mention that it is just as easy to drop one's voice as to drop one's head. Probably very few of us have had lessons in voice production or public speaking, and nervousness and concentration on the talk can quickly find expression in lowering one's voice without realizing it. This applies particularly to those with naturally soft voices; a conscious effort has to be made to throw one's voice especially when talking to a sizeable audience or in a large hall. The old words of advice "Look up and speak up" are well worth remembering.

Humour, although not essential, can be a very valuable ingredient in a talk. Laughter both helps the audience to relax and creates an easy atmosphere. The best jokes are usually unplanned and spontaneous and depend very much on one being in tune with the audience's mood. I used to think that to make people laugh was a most difficult task and would spend hours searching through popular monthlies for a suitable joke to relate, only to discover that an anecdote about hospital life recalled on the spur of the moment never fails.

The idea of having to answer questions "off the cuff" at the end of a talk can be quite off-putting to the beginner. However, "question time" can be both interesting and stimulating and it is also very rewarding for the speaker to realize just how much thought has been provoked amongst the audience by what has been said. In my experience no audience is critical about a particular question but in any case it has never proved as difficult as I anticipated to phrase a thoughtful answer, for when all is said and done there are few topics that I know more about than my job!

This must of course apply generally, for even if we are not all experts on the subject of medical social work at least we know a great deal about it. Confident in that knowledge, please do not hesitate to accept the next invitation — or is challenge a more appropriate word? — to speak about your work in public. You will probably be as surprised as I was to find just how much you enjoy it.

Sanatorium Board of Manitoba Sets Up Rehabilitation Research Fund

A Manitoba Rehabilitation Hospital Research Fund, amounting initially to \$15,000, was formally established by the Sanatorium Board of Manitoba at an executive meeting of the Board.

The fund will be used to finance research of a clinical and basic nature in the field of physical medicine and rehabilitation. The research will be guided by a Directing and Advisory Technical Committee, composed of four doctors who have special medical research knowledge.

Others May Help

When announcing the establishment of the fund, the Sanatorium Board expressed the hope that private donors would aid in building up and developing the funds for research in this important area of medicine.

In its modern sense, the specialty of physical medicine is barely more than 20 years old, the Board points out. And although research is now being undertaken in many centres throughout the world, the level of knowledge in this area is considerably lower than that of medicine as a whole.

The Sanatorium Board feels there is an urgent need to close the gap as quickly as possible. Scientific advances in this century have made it possible for more people to live longer. Many survive with serious disabilities; a great many more are advanced in years.

Since medical science is responsible for the accumulation of these persons, we owe it to them — and to society as a whole — to help them back to as normal a life as possible.

Excellent Facilities

The Manitoba Rehabilitation Hospital is equipped to provide treatment programs for all types of disabilities, including arthritis, paraplegia, hemiplegia, strokes, neurological and orthopaedic conditions and amputations.

In the two and one-half years since the hospital was opened, over 4,000 Manitobans have received treatment either as in-patients or out-patients. Many have been helped to return to work, some have learned to walk after years of confinement to a wheelchair. A large proportion have gained independence in looking after themselves and are now contributing to the work of the home.

The concentration of patients with all kinds of disabling problems, the research facilities of the Manitoba Rehabilitation Hospital, and the proximity of the hospital to other medical facilities and specialists in the Manitoba Medical Centre, offer an excellent opportunity to advance and clarify the rehabilitation process.

According to Dr. L. H. Truelove, chief of medical services, research could be carried out at the following levels:

Clinical: Doctors need to know more about the natural development of the diseases being treated and the effects of the treatments now used. A start has already been made, with an analysis of 200 patients with rheumatoid arthritis and a report on the results of the treatment program for patients who have had strokes. But a great deal more could and should be done.

Physiotherapy and Occupational Therapy: Much work is needed on the efficacy of treatments we are now using in relation to the results in specific patients. Such a study would indicate further development of those techniques which show the most promise.

Prosthetics and Orthotics: Although considerable advances have been made in this field during the past few years, there are many problems relating to mechanical devices which require urgent study.

Basic: In this area, there is much doctors need to know about, for example, the function

(continued on page 29)

Employment of the Disabled

Ninth World Congress of the International Society for Rehabilitation of the Disabled

The Report of the Ninth World Congress of the International Society for Rehabilitation of the Disabled has just been released. It contains papers delivered at all sessions; reports of discussions; and resolutions adopted by the delegates. If you are interested in any area of rehabilitation you will find something to interest you in this comprehensive document.

Of particular interest to the Civilian Rehabilitation Branch of the Department of Labour, was the report on the panel discussion, "The Disabled and the Labour Market", chaired by the National Co-ordinator.

In introducing the discussion, Mr. Campbell quoted a remark of Mr. Hall H. Popham, president of the International Society for Rehabilitation of the Disabled — "The ultimate goal of all rehabilitation is to enable the handicapped individual to work . . . A job is essential, not only to enable the individual to be economically self-supporting, but also to assure him his rightful place in his home and community."

Mr. Campbell went on to state that rehabilitation was a subject of concern to all nations regardless of the condition of their economies. Every person, disabled or not, he said, had a right to the place in life for which his nature, inclinations, skill and training fitted him, and within the range of opportunity provided by the society in which he lived. Many disabled people, however, must be prepared for and guided into work which, in the majority of cases, involved an employer-employee relationship.

In such relationships, the success of a vocational rehabilitation program in any country depended substantially upon the attitude and co-operative spirit of organized workers and employers. They in turn were influenced by the sincerity and practical approach of those who work

with the disabled and by the guidance of their international organizations. All were affected by the work and direction of the International Labour Organization which had continued to support the development of vocational rehabilitation programs in all member nations.

Views of the ILO

A. A. Bennett, representative of the Vocational Rehabilitation Section of the International Labour Organization, discussed some of the difficulties encountered in resettling the disabled and how they might best be met. He noted that in a buoyant, expanding economy when labour was difficult to obtain, it was usually a simple matter to fit the disabled into suitable positions. But in a stagnant economy, times of depression, or where there were problems of over-population, widespread unemployment or under-employment, placement of the disabled was particularly difficult. He suggested that under these conditions, special attention should be given to the selection of fully qualified disabled persons on the basis of their ability to compete on equal terms with qualified, able-bodied applicants with whom they should have equal opportunity for employment.

Vocational training and other pre-employment preparation should be concentrated on producing highly-skilled workers for whom jobs might exist or who might be helped towards self-employment but who, in any event, would have ample opportunity for employment because of their established levels of skill. The objective in the case of disabled persons, for whom the prospects of obtaining paid employment or becoming self-employed would be slim, might well be the setting-up of sheltered workshops or some form of co-operative enterprises.

Even in the richer, more industrialized and more socially developed countries, employers were sometimes reluctant to engage the disabled because of misconceptions concerning their work performance, absentee and accident rates, sickness incidence, and levels of stability and employment. Trade unions generally were sympathetic to the needs of the disabled, especially the needs of their own members, but they shared the misconceptions of employers and the general public. The support of trade unions and employers could be obtained through factual publicity and by enlisting their co-operation in measures to improve work opportunities for the disabled.

One of the biggest obstacles to employment of the disabled, cited by the speaker, was the pre-employment medical examination demanded by many employers. Too frequently these examinations resulted in the exclusion of otherwise suitable persons simply because they were unable to meet the strict and artificially high standards which in many instances bore no relationship to the specific requirements of the work.

The speaker thought that governments could further the cause of rehabilitation by fitting medical standards to the requirements of employment in the government service, and could also take the lead in providing jobs for the disabled. He said that in many countries employers generally were awaiting a decisive lead in this direction by their governments.

Views of Organized Labour

In outlining the views of organized employees, Alfred Braunthal of the International Confederation of Free Trade Unions, listed certain matters of concern to these groups. They looked forward to the establishment of centralized governmental or government-controlled organizations with authority to establish rules for the rehabilitation and employment of the disabled and having powers of enforcement. The unions would also like to participate in the drafting and implementation of these rules.

They considered that sheltered workshops should be provided for disabled persons who could not be expected to conform to the requirements expected of them on the general labour market.

It was their opinion that, be it determined by law, by established rules or collective agreements, a proportion of jobs at all major work centres should be reserved for the disabled.

They were concerned that fair wages be paid the disabled; either the regular wage as fixed by collective bargaining agreements or, in the case of reduced work capacity, a percentage of the wage equivalent to that capacity. They indicated that work councils should protect the interests of handicapped workers on the job.

Views of Organized Employers

Johannes Ammundsen of the International Organization of Employers noted that placement of the disabled in suitable occupations was the entire aim of the rehabilitation process. It was generally accepted that medical care and financial support alone were insufficient and that the fullest possible restoration of working abilities was of supreme importance both to the disabled and to the community in which they reappeared as useful citizens.

Mr. Ammundsen reviewed certain problems involved in the placement of disabled persons. He believed that some countries had a larger number of disabled than others, such as those with a high percentage of war casualties. The general employment level in a country was also a factor to be considered. Under conditions of full employment, employers often found it advantageous to engage disabled persons. From an economic standpoint the disabled who returned to the labour market constituted a welcome source of labour. The success of rehabilitation efforts and placement of the disabled in the normal labour market was therefore largely dependent on the success of a policy of full employment.

In certain parts of the world, however, the supply of labour far exceeded the demand. In such circumstances, disabled persons could not expect to find an abundance of regular occupations and therefore the aim must be to encourage their useful employment in other fields.

The speaker felt that while there was a growing trend toward employing the disabled, some employers still lacked the necessary understanding of their problems. He noted also that the ma-

(continued on page 15)

Counselling Handicapped Adolescents

by DR. S. R. LAYCOCK

Counselling, as distinct from the mere giving of information, requires many basic skills and considerable understanding. Counselling handicapped adolescents makes many additional demands on the counsellor.

Successful counselling of handicapped adolescents depends upon five main factors: (1) an attitude of acceptance on the part of the counsellor; (2) a basic understanding of the meaning and purpose of counselling; (3) an awareness of the basic psychological needs of the adolescent — for belonging, independence, achievement, recognition, self-esteem; (4) an awareness of the particular problems of adolescents in general and of the handicapped adolescent in particular; (5) an understanding of the process of counselling, i.e. the changing of the individual's self-concept.

Attitudes of the Counsellor

Untrained persons often fail to understand that the stages of this process are first acceptance, then understanding and then guidance. The writer has emphasized this in his book, "Pastoral Counselling for Mental Health", (Ryerson), in which he points out to clergymen that the acceptance of the person concerned as a worthwhile individual precedes both understanding and guidance. Actually, most people put up defences and barriers lest they be understood by those around them. Genuine respect for an individual, interest in his welfare and lack of pity and condescension are prerequisites of successful counselling — certainly of adolescents and, in particular, handicapped adolescents.

The Meaning and Purpose of Counselling

Counsellors who are not fully trained tend to regard their job as that of reviewing relevant

information regarding the subject's personal assets and liabilities, then persuading him to accept what they believe to be a logical decision. They forget the well known definition of counselling: "Helping Johnny to see through himself so that Johnny may see himself through". Proper counselling assists the subject to sort out his assets and limitations and results in his own decision to accept them with confidence. In other words, good counselling is not a manipulation of the person's mind toward a cut-and-dried conclusion but is instead a process of self-discovery and self-acceptance.

Awareness of the Basic Needs of the Individual

Handicapped persons share with others certain basic psychological needs. These are: (1) the need for affection — to live in reciprocally warm regard with one or more human beings; (2) the need to belong — to feel a valued member of a group (family, recreational, or community); (3) the need for independence — so far as possible to order one's own life and make one's own decisions; (4) the need for achievement — the successful accomplishment of personal undertakings; (5) the need for recognition — to feel that oneself and one's actions merit the approval of others, especially of one's peers; (6) the need for self-esteem — to feel that one measures up to one's own standards; (7) the need for understanding and explaining the world around one; (8) the need to understand oneself and to achieve one's potential.

Many psychologists believe that these needs add up to one fundamental requirement — the need for a sense of adequacy. This is definitely the pressing need of the handicapped individual and it is important to recognize that he acts in terms of satisfying his needs and in accordance

with what he believes. This means that his behaviour stems from his self-concept — how he feels about himself — whether worthy or unworthy, accepted or rejected, competent or incompetent, and in terms of his real or imagined handicaps. It is increasingly accepted that an individual's actions towards others, how he perceives their reactions to him, and how he meets life's problems is dependent on his self-concept and on his feelings of frustration or satisfaction. Assessing the degree of limitation imposed by an adolescent's handicap is not enough. How he himself feels about his handicap may be of equal or even greater importance.

Awareness of the Problems of Handicapped Adolescents

All adolescents face problems characteristic of their stages of development. They must: (1) adjust to changing physical growth and development; (2) gain emancipation from adult control; (3) adjust to the opposite sex; (4) plan and prepare realistically for a vocation; (5) find a philosophy which gives meaning and purpose to life. Handicapped adolescents often face these problems in exaggerated form.

Because he is acutely aware of his physical limitations, the handicapped adolescent often finds difficulty in adjusting to bodily changes. He may be unusually disturbed if maturity is advanced or retarded and he may need help in understanding that the size of his genitals, in comparison with those of others, has no relation to potency. He may become disturbed at seminal emissions or misinformation about the harmful effect of masturbation. The adolescent girl may become disturbed by the onset of menstruation and the growth of breasts and hips and may need help in accepting these changes as evidence of growing up. In these situations mere information may not be enough. The adolescent may need help in eliminating feelings of fear, guilt, and embarrassment.

Gaining emancipation from adult control is, perhaps, the major step in the development of the adolescent and he should assume control of his life. Failure to do so is likely to result in faulty development of personality. Depending on the nature and degree of his handicap, the

adolescent often faces unusual hazards in this regard. Because of his handicap he may of necessity have become largely dependent on his parents and have been excessively protected. He may need help, and his parents may need help, if he is to achieve emotional independence and psychological meaning from them. He must have every opportunity to make decisions and to manage his own life. Counsellors must help create and develop a feeling of competency by assisting him to recognize his assets and by reducing parental dependence. He must have adequate opportunity to mingle with other adolescents if he is to find confidence and security in their company. Self-help must be encouraged.

Adjusting to the opposite sex is often a major problem for the handicapped adolescent due in part to the high value placed on beauty in girls and strength and games-skill in boys in present-day adolescent sub-culture. A physical or mental handicap is likely to make the adolescent less desirable as a date or a mate both in his own and others' eyes. It may exclude him from dancing and from other normal social activities — and finding ways to include the handicapped adolescent in the "crowd" is often difficult but highly important to his development.

Probably the greatest challenge of all is the counselling of the adolescent whose physical or mental handicap makes marriage and family life impossible, improbable or unwise. To help him face this situation realistically requires competent and kind counselling, probably over a period of time. It is desirable to plan for and provide as many opportunities as possible for friendship with the opposite sex in as natural a setting as possible.

Vocational Counselling

Rehabilitation services are deeply interested in the handicapped adolescent. Work gives normal satisfaction for most of humanity's needs — for belonging, independence, achievement, recognition, self-esteem, and self realization.

Vocational counsellors must be skilled not only in helping the adolescent assess his own strengths and in understanding the requirements of a wide range of jobs, but also in helping him adjust to the world of work. In many cases specific vocational training is not as important

as the personal characteristics, attitudes and habits of the trainee. It is increasingly recognized by educators of the handicapped that it is of major vocational importance that children receive early training in getting along with others, in being dependable, responsible and trustworthy, in sticking to a job until it is finished, and in doing a thorough job. Without such qualities, many handicapped youth are doubly handicapped in the world of work.

All adolescents are searching for a sense of identity. They are aware of themselves in a new way as persons and as future workers, lovers, parents and citizens. In primitive societies adolescents were given a full place in the adult world at puberty. In the pioneer life of this country the adolescent usually had an early share in adult responsibilities. In modern urban society the adolescent shares less and less in the work of the home and takes little part in community life. Some sociologists believe that the extremes of behaviour often found among today's adolescents are simply reaction to a sense of frustration in a world in which they seem to have no place and which does not welcome them to the realm of work. This sense of hopelessness and futility is likely to be increased in the case of handicapped adolescents.

Adolescents find themselves concerned with problems of destiny and the meaning and purpose of life. Indeed, one of their jobs is to come to terms with mankind and work out a philosophy; they will need help in understanding the world around them and their own place in the scheme of things.

Techniques of Counselling

Theories of counselling differ with respect to the extent to which the process should be directive and non-directive. Certainly, educators are more and more convinced that learning to be effective must be an active process — that of self-education. Counselling in its best sense is a learning process in which the recipient does the learning. This usually produces a change in his self-concept and, as a result, in his perception of others and his approach to life's problems. It involves encouraging the person concerned to examine his feelings, to assess his strengths and

to accept his limitations. It will usually involve a certain degree of non-directive counselling and several interviews. Otherwise a decision not evolved by the subject will be ineffectual.

Rehabilitation is not merely an intellectual decision or a mechanical program of training; it is a restoration of the entire person, and this is particularly true in the case of the handicapped adolescent.

(continued from page 12)

majority of disabled persons were steady workers and in conditions of full employment, when fluctuations within the labour force were increasing, this became a particularly valuable quality. Organizations of employers and of labour could help materially to return the disabled to the labour market and this was important not only because it benefitted the disabled but because they, as a source of manpower, represented a productive contribution to the national economy.

Views of the Disabled

Raimondo Magnani, president of the International Federation of Disabled Workers and Civilian Handicapped, spoke for the disabled and drew attention to the fact that while their numbers had increased, technical progress was limiting the employment opportunities of unspecialized labour. Thus it was obvious that the handicapped must have ample opportunities for education and vocational preparation.

The speaker had reservations about compulsory employment systems in effect in some countries. He felt that the handicapped person was often assigned work beneath his ability whereas the employer found himself unable to employ the handicapped profitably and regarded compulsory employment as an imposition on his business.

A placement system which could assign the disabled person to a position suited to his capabilities and training seemed to the speaker to be the ideal solution to the problem of helping that person find his rightful place in society.

Rehabilitation at St. Vincent Hospital



Bernadette comes to meet Mr. Viau when he calls to check on the fit of her limbs.

Photo by Dominion-Wide

At one time, St. Vincent Hospital in Ottawa was looked upon purely as an institution for incurables and for the care of the elderly. Today this bustling, 525-bed hospital has an active rehabilitation program. Many of its patients are long-term cases requiring prolonged therapy to teach them to walk again. Many have been restored to a point where they can resume work and take their places in the community.

St. Vincent boasts a special children's department where youngsters suffering limb defects, either from accident or birth, receive treatment, and where regular school classes are provided for those of school age.

All artificial limbs, built-up shoes, spine supports, knee braces and other equipment required by patients are made on the premises. Armand Viau, who is in charge of this work, started his career as a machinist and die maker in Ottawa. At the request of the hospital, Mr. Viau took the regular anatomy course at the Medical School of the University of Ottawa and then underwent

special training in New York and Toronto in the making and fitting of artificial limbs and other orthopaedic appliances. In his work at the hospital, Mr. Viau has had considerable experience in fitting amputees with artificial limbs and has developed a new technique for reducing edema and preventing contraction of the stump of an amputated limb.

The most notable amputation case Mr. Viau has dealt with is that of little Bernadette. At the age of two, Bernadette had both legs amputated above the knee after being run over by a tractor. Now, at six, she walks to school on new suction-top artificial legs, products of Mr. Viau's skill.

St. Vincent Hospital authorities have confidence in the ability of disabled persons to give satisfactory service in employment and one of the things which strikes the hospital visitor is the number of wheelchair patients employed full-time as clerks, stenographers, and switchboard operators. Other patients leave the hospital each day for outside employment, returning at night.

New Stump Correction Technique

By ARMAND VIAU, C.O.,

Chief Prosthetist and Orthotist, St. Vincent Hospital, Ottawa

A frequent problem encountered by prosthetists in fitting artificial limbs for new, above-the-knee amputees is that caused by improper bandaging. Almost invariably it is found that the bandage was not kept properly in place and in some cases was discarded with the result that the stump has become flabby. If the figure-of-eight bandage with Spica is improperly applied a flexion contracture will occur. This condition is particularly prevalent among older patients.

Under these circumstances, it is necessary to refer the case to physiotherapy treatment for correction. This delays rehabilitation several weeks to a month. Delays are costly and frustrating for both the patient and the community for a hospital bed is required during treatment as are the time and services of staff.

A new technique has been developed at St. Vincent Hospital to cope with this problem. The method has proved effective in reducing by half the time required to correct the flexion contracture or in preventing it entirely. Since antagonist muscles are relaxed during sleep this technique is particularly effective when applied during day-time hours of rest and reaches maximum effect when applied at night.

The new technique makes use of:

- (a) A waist belt of 2-inch, firm webbing, having a 1-inch safety buckle sewn anteriorly.
- (b) Three 1-inch elastic webbings approximately

eight inches long with a safety buckle sewn at the top of one end by means of a 1-inch webbing.

- (c) Three grip-ends of a type large enough to permit threading the 1-inch elastic webbing through loops.
- (d) One heavy woollen stump sock one or two sizes smaller than the stump.

To assemble, sew two of the elastic webbings (ends with safety buckles) to waist belt posteriorly over gluteus maximus muscles and the third one anteriorly so that it comes down the front of the stump in the mid-line. Thread each strap through a grip-end and attach end of strap to buckle at the waist band.

Put stump sock on patient making sure that at least 3 inches of sock extend beyond the stump. This is the reason the smaller sock is used. Place the waist belt on the patient in standing position preferably and fasten the two back grip-ends to provide necessary tension for extension of stump.

Fasten the anterior grip-end to the stump sock with little or no tension. Its purpose is merely to keep the stump sock from slipping off.

This method has been approved and employed under the supervision of Dr. René Allard, Consultant Psychiatrist at St. Vincent Hospital in Ottawa and at Ste-Justine Hospital and Hôtel-Dieu in Montreal.

Front View

Side View

Back View



Pre-School Centre for the Deaf

By MARY HUGUES, M.S.W.

*Co-ordinator, Pre-School Centre,
Society for Crippled Children and
Adults of Manitoba*

During the past decade, educators, therapists and other professional workers concerned with the welfare of the deaf child and adult have, with increased diligence and authority, pointed out the need to utilize effectively the crucial formative years of the deaf child's life to assure that he is helped to use all his potential to develop a means of communication within a hearing world. It is now known that the young child can learn oral communication, including lip-reading skills and speech, if he receives specialized and intensive training during the period when a hearing child develops normal speech. Such international organizations as the John Tracey Clinic in Los Angeles and the Alexander Graham Bell Association have played an important role in bringing to public attention the vital need for pre-school education for the deaf. Through literature, correspondence courses and stimulation of parent associations in local communities, these organizations have reached areas which would otherwise have been isolated, and have challenged and inspired parents as they have been given hope for the deaf child. The emphasis on the urgency of intensive training during the pre-school years places a burden and responsibility on many parents who, though willing, are unable to carry out the task of training without the help and guidance of specialists in the field of education for the deaf.

In Manitoba, programs are now being developed to bridge this gap and provide services for the pre-school deaf child. As a result of the co-operative efforts of the Pre-School Deaf and Hard of Hearing Parents' Council, the Kinsmen Club of Winnipeg and the Society for Crippled Children and Adults of Manitoba, the Pre-School Centre for the Handicapped was opened in September, 1964, to expand services already

provided for the orthopedically handicapped pre-schooler in the Cerebral Palsy Centre and to develop new services and programs to meet the needs of the deaf child of Manitoba before he reaches school age.

The Centre is located on the main floor of the new Kinsmen Building for the Handicapped, which is also the headquarters of the Society for Crippled Children and Adults, 825 Sherbrook Street, Winnipeg. Two nursery school playrooms, and individual and small group classrooms provide areas to work with children individually and in groups. There are speech therapy and audiological testing facilities. Observation rooms, adjacent to all activity areas, are being used constantly for professional training of such groups as nurses, medical students, therapists, psychologists, social workers and for general public education. They are invaluable to staff and parents in planning the day to day care of children referred to the Centre. What is even more important, the Centre has become "a small child's world"; a place where a child learns while he plays, and where parents are finding associations and experiences which help them gain confidence in themselves and in their abilities to carry out the special, as well as the normal tasks of mothering their pre-school deaf children.

In this setting, the Pre-School Centre for the Deaf is now offering comprehensive services for all pre-school deaf children of Manitoba through individual services with parent and child or in group programs. Any child up to school age, resident of Manitoba, may be referred by doctors, hospitals, health units, social agencies or by parents themselves. Eligibility is determined following an assessment by a medical team which includes a medical and developmental study by Dr. W. Grant, Medical Consultant; otological

examination by Dr. J. Rubin, Consultant Otologist to the Deaf Program; and assessment by the Speech and Hearing Clinic are used when available. This medical assessment has been planned to assure that only children whose hearing impairment can not be treated medically, are accepted for training. It is also hoped that a more concentrated and intensive study of the medical histories of children referred to the program, will increase our understanding of the individual child and also provide data for research in such topics as the etiology and early diagnosis of deafness.

It has been said that with the diagnosis of profound deafness, the problem of the deaf child is no longer a medical but rather an educational and social problem. During the pre-school years when assessment, training and learning are so closely related to developmental processes, it is important to exploit the dynamic growth and maturation process of early childhood. To achieve this goal the Pre-School Centre has developed a number of programs to meet the normal as well as the special needs of these children. Social work and parent oriented education programs are directed to enhancing the child's welfare in the home and assisting parents to develop special skills essential to the training of the child. Assessment and training resources for the deaf child are available, individually or in group programs and include audiometric testing, auditory stimulation, orientation to hearing aids, sense training, lip-reading and language development. Group programs provide an opportunity to integrate planning for language development in a social environment which stimulates growth through relationship with peers and adults, and through achievement of skills in challenging physical and mental activities.

At the present time the Centre offers three group programs for city children which includes a Toddler Group for the very young child accompanied by mother, and two groups for children in the age range of three to six. A summer program for rural children is offered in July to provide the same services of assessment, training and parent education for the rural child. The goal is to help the parent understand the problem of deafness and through the process of assessment and demonstration help her gain con-

fidence in herself as a teacher of her child. All rural children under six years will be accepted in this program, provided the mother can make arrangements to accompany her child. Though four weeks attendance is recommended, shorter periods for assessment and parent orientation, supplemented by a follow-up program throughout the year has proved effective in planning for parents referred to the rural program last summer.

During the first year and a half, the Pre-School Centre has directed its attention to the development of services and programs for children and parents referred. In this time much has been learned about the deaf child and his parents. We have also learned that it is essential to integrate the professional insights and skills of social workers, speech therapists, teachers of the deaf and nursery school teachers to assure that the total potential of the child is utilized in the educational processes. Much more is yet to be accomplished. The program is new and will expand. Staff will gain more skill and understanding through experience and training on the job and as new knowledge about children in general, the deaf child in particular, becomes available. One of the major tasks at the present time, is to assure that all deaf children have the opportunity to benefit from the services now available. As the problem of deafness is usually identified by family physicians, Health Units and Childrens' Clinics, the Centre primarily depends on the medical profession for case finding and referral. Doctors have long recognized a need for special services for the young deaf child and we anticipate they will welcome this resource the next time they are faced with the painful task of telling parents that their child is deaf.

Ontario Hospital School—Cedar Springs

Kent District in the Great Lakes Region held its third annual Family Picnic last August, with over 250 people in attendance.

Among the gathering was the Ontario Hospital Schools Group of Scouts from Cedar Springs which made a splendid showing during the competitions. They placed second in point standing and first in "enjoyment standing".

(The Phoenix, April, 1965.)

Retraining the Middle-Aged

by EUNICE BELBIN

*Director, Research Unit into Problems of Industrial Retraining,
University College, London, England.*

Technological progress in industry demands an increasing proportion of trained workers. Experience suggests that much more attention will have to be given to training programs for adult workers who need to learn new skills because their previous jobs are now done by machines. In the following article Dr. Eunice Belbin, who has been engaged in research into the problems of persons displaced by automation, discusses the difficulties and prospects of retraining middle-aged workers. It is reprinted from the March 19th, 1964 issue of New Society with permission of the author and publisher.

"I've dropped thirty bob since I moved off the production line, but I'm grateful to the MO for fixing me up with this job." The speaker, a worker in a factory engaged upon mass production of motor vehicles, was in his early fifties and had been transferred to a less hurried machine minding job following a breakdown in health. He was now all prepared for the next decade on a job where he was less likely to lose his grip.

His experience is common to many in their middle working years. In this same factory, for example, a medical study showed that 6.5 per cent of the unskilled men in middle life were recommended by the works' doctor for a job change, together with 3.9 per cent of the semi-skilled and 2.1 per cent of the skilled over-forties. These men were fortunate in that most were able to remain within the firm. Some were upgraded from unskilled to semi-skilled work and a few from semi-skilled to skilled. But, for the majority of those in industry who have to change jobs in middle age, loss of status, income, or both, are the expected consequences of ageing.

The possession of a skill for which there is an effective demand offers a man a much greater measure of security. But how often is the displaced worker provided with the alternative of training for a new skill? Do we know whether he could make the grade if he were given this

opportunity? Much is said about the dispirited 80 per cent who "fail" the 11 plus; very little consideration has been given until fairly recently to the plight of a large body of middle-aged people who fail the 40 plus — in fact, their failure is so presumed that they are not even given an opportunity to take a test.

The subject of changing occupation and job in middle age is becoming one of increasing practical importance as very few young people starting work in industry today can expect to do exactly the same job until they retire. An American survey has shown that at the age of 40 a man may on average be expected to engage in two or more job changes before he retires. In this country, too, constantly changing requirements of a science-based economy are expected to lead to radical changes in the nature of jobs so that a growing proportion of adult workers whose skills have been rendered redundant by technical progress will be required to learn some new skill or to modify a skill they already possess. In addition to this need for retraining within industry, various influences are tending to cut off the supply of labour at the other end of the age scale: raising of the school leaving age, extension of further education, general preference for entering non-industrial jobs, and so on. It seems likely, therefore, that industry will be obliged to recruit for semi-skilled work people normally

considered as being above the age for training.

This need to train or retrain the adult worker is beginning to gain acceptance. Several industrial concerns have recently reported the successful retraining of middle-aged men who would otherwise have been discharged. The decision to take such positive steps is welcome. Yet the very fact of reporting the success in the industrial journals pays tribute to the originality of the idea.

A number of surveys of employer opinion have testified to the merits of middle-aged and older workers — their conscientiousness, good time keeping, relatively high sense of responsibility, loyalty and so on. From these surveys it has often been deduced that there is an overwhelming case, both in the interests of the nation, and of the employer, for people in middle or late maturity to be taken on and trained. Yet there are very few instances in industry in the United Kingdom where training schemes admit middle-aged recruits. Many employers use age as a criterion of acceptance. Adults tend to be excluded for a number of reasons. First, they are a far more expensive proposition than a school leaver. During the training period the recruit must be subsidized for his non-productive work, and it is cheaper to subsidize at a juvenile's rate rather than at the full rate. Secondly, and perhaps more important from the point of view of ultimate progress, there is the deeply ingrained belief in industry that a middle-aged man is generally too old to learn new skilled or semi-skilled work. What evidence is there to support this view?

Older workers are at a disadvantage at the start, for, in the aggregate, they differ from younger workers both in adequacy of education and in the relevance of their existing skills. But even where these factors have been equated, there is some evidence to show that not only do older workers take longer to learn a skill, but in some cases they appear incapable of achieving standards attained by the younger recruits. In the hosiery industry, for example, there is evidence that sewing machine operatives trained over the age of 35 not only took considerably longer than school leavers to acquire the skill, but they seldom attained the speeds of which the young girls were capable. In the General Post Office's

London Postal School, where recruits for manual sorting duties are accepted for training up to the age of 60, it has been found that in spite of the levelling rendered by a stringent selection test, there is still a considerable difference in the pass rate in favour of the younger entrant.

Quite apart from employer reaction, there are the personal difficulties of the older trainee. Is an older man going to receive a wage that is adequate to keep him and his family over the full period necessary to learn a new skill? Very often, with jobs which are classed as skilled, there are regulations which specify the period of apprenticeship and which act as an age barrier to all but juvenile recruitment. There is considerable evidence drawn from the United States, United Kingdom and other West European countries to show that older applicants are often more reluctant to present themselves for training courses, especially in competition with younger people.

They are also much more likely to leave during the early stages of training. One study in this country showed that a firm in Lancashire which planned to start a shift solely for middle-aged workers had only 30 applicants arrive for interview out of 90 who had been invited to attend. Fifteen of these were appointed. After six months, those still employed had dwindled to three, although only one had been discharged by management.

On the other hand, there is a limited amount of evidence of older people being trained successfully, often at very difficult skills. It is rare, however, to find a company which retrain older people for more highly skilled work, while at the same time keeping records of their progress and noting the methods used to overcome special problems.

No Dismissals

One notable exception is Guest, Keen & Nettlefold, in Birmingham. This firm was proceeding towards automation, but still employed many unskilled labourers, some of whom were highly paid. It had been agreed with the trade union that no one should be dismissed as a result of technical progress, nor have his earnings cut without due compensation. Four labourers, all in

their 50's, insisted on having a job in which their previous high earnings might be retained. The only solution within the company's new wage structure was to train them for skilled work, which in this case was as setters on automatic machines. This normally entailed 14 weeks of concentrated training. At the commencement of training many difficulties were experienced, including that of building up the trainees' confidence in themselves, but after training had been extended to 20 weeks all four were successfully transferred to production.

Another very successful pioneer effort in this field of retraining for the purpose of upgrading the middle-aged worker is reported by the Rank-Bush-Murphy organization. Their factory in Welwyn Garden City has, consequent to the merger, prevented the redundancy of a large number of middle-aged wiremen who were working on domestic radio and television sets. It transpired that following the regrouping of productive capacity there were a number of vacancies in the industrial electronics division for which no trained men were available. The question was whether these semi-skilled men could possibly be trained to work to precision limits on a much wider range of equipment, working from schematic diagrams.

As an exploratory experiment six of the company's technical staff volunteered to take classes in their spare time, if volunteer "pupils" could be found among the wiremen. This offer was warmly supported by the trades union representatives, and, in consequence, a volunteer class of 15 men, mainly between the ages of 40 and 50, received training for a period of two hours for two evenings a week on an eight week course.

The experiment appeared to be a complete success. The men were transferred to their new jobs and the company began to develop training programs in earnest. "I admit we did not think some of them could make it," reported one of the instructors, "but their progress has been remarkable."

But these are isolated examples; in each there was a special environment which may have masked the difficulties encountered by the older learner. In all cases, the employer was the same for both the old and the new job. The change-

over could thus be well planned and agreed by employer, employee and union. The men in question knew they had a job to go to and, in most cases, a job with added status. Previous social groupings could be maintained and the general problems inherent in the older man presenting himself for training in an unknown environment were minimized.

That there are still difficulties to be encountered by the older learner which are likely to transcend these social and environmental factors, however, is obvious from the psychological studies of ageing. Recently attempts have been made in a practical setting to combat these difficulties by the adaptation of training method. Steel, Peach & Tozer, of Rotherham, for example, had previously encountered some difficulties in initial attempts to train older workers to operate their new, highly technical processes. The company had received advice that older trainees tend to absorb what they see rather than what they hear, and it was decided accordingly that lecturing should be minimized and that initial training should consist of simulated exercises, working to a written brief with models of control panels, furnaces, etc. Once the procedures had been grasped, the trainees were able to practice by themselves at their own pace and after a period on similar processes in other factories the men were able to operate the new plant when it came into commission. Thus the company has now successfully retrained men of an average age of 50 who normally work on open hearth furnaces in melting shops to operate electric arc furnaces.

Some of the fundamental difficulties encountered by the older person in learning a new skill have recently been studied in an experimental setting in the London Postal School for GPO manual sorters. As a result, a new training method has been designed for one London district to meet the special requirements of the ageing trainees, and the failure rate reduced considerably. Recruits were trained by the traditional method and by a new experimental method for a parallel trial period. Even within the normal time limits of training, the performance of the middle-aged group when training was suitably adapted was comparable to the usually accepted standard of their younger colleagues.

An extension of training time was allowed to those who seemed worthy of further instruction.

Perhaps the most important outcome of the studies in the London Postal School is the evidence that the older trainee benefits most from learning by discovery, by free decision or discrimination in a fairly open situation. Learning by this method seems to acquire for him a greater permanence than when learning is governed totally by instruction, perhaps because the latter permits the trainee to become mentally passive. Every stage of a task must be adequately challenging to the older learner: given a task which is too easy in presentation, he doesn't take up the challenge. "Playing at kindergarten stuff," was a typical comment by a 50-year-old worker on a mental task which had been broken down into component parts in order, as it was thought, to help him to learn it.

This method of learning by creative thinking is being increasingly advocated and developed in other fields of education and for far younger learners than middle-aged manual sorters.

But if optimum learning conditions are to be provided for the middle-aged trainees of industry, a certain reorientation of traditional training methods is required. But this will need to take into account factors other than method of assimilation. We have already pointed out that breaking the job down into unreal and "easy" tasks may be resented by the older trainee and waved aside as "kid stuff". But there is a more fundamental reason why this method of teaching should be psychologically unsound for the older learner. The studies of the manual sorters in the London Postal School suggested that although the man of 40 plus was unexpectedly good at acquiring information, he did have relative difficulty in retaining what he had learned. When he was asked, for example, to learn A, then B, then C, he learned each very well. But if he was then asked what he remembered of A, there was every chance that he had forgotten it. Unless he had really consolidated his learning of A, the subsequent learning of B and C seemed to interfere with retention of it. In practice, it was found advisable for these older learners to learn A, then always to revise A with the learning of

B; then to revise A and B with the learning of C and so on.

Teeth Into the Job

Because of this rapid forgetting of new learning by the older person, long sessions of practical work were found advisable for him. And, unlike the youngster who benefits from and looks for the occasional breaks in the learning program, the older man seemed to enjoy settling down to a long session, where, as he puts it himself, he could "get his teeth into the job in hand". He didn't appreciate being taken off the learning job to see a documentary or be provided with a change of activity to prevent boredom. The procedure of giving long training sessions to the 40 plus has been received with scepticism by some traditional trainers of industry, who have been brought up to believe that it is psychologically incorrect to go on for too long at one subject. (There are obviously many conventional attitudes to overcome if the 40 plus is to pass successfully through an industrial training program.) These relatively long practice periods also provide an opportunity for the 40 plus to tackle a sizeable job and, in turn, to let him see the end-point of his studies. He favours knowing *where* he is going, even if he prefers getting there under his own steam. Thus it was found expedient to provide the framework in which the 40 plus could structure his own learning rather than to break the task down for him. This self-structuring has the advantage, too, that it allows for the many different starting points of learning which will obviously be necessary with a group of men drawn from highly different backgrounds and experience.

One effective way in which a break in continuity may be provided during the older learner's training is to vary the method of teaching rather than the material being taught. Psychological experiments in the laboratory have shown that "retroactive inhibition" (the effects of subsequent learning on something previously learned) can be reduced by varying the method of intake. Thus several parts of a learning program may gain identity or isolation in memory and be better retained by allowing each to be assimilated in a

different way. This procedure was adopted in the London Postal School, where five different methods of learning were used for successive stages of the teaching of some 600 London place names and their respective district numbers.

Middle age brings other problems to the training school. Human beings are bad at making predictions; they get worse as they age. If a middle-aged worker on a process control plant finds that the dial is registering danger, he will tend to look to the boiler — merely because it was the boiler which caused the trouble last time. The 40 plus does in general find it difficult to rid himself of an idea he has once accepted in favour of a new response. This makes for problems in learning, brought about by the difficulties of “unlearning”. Although the older learner will often use accuracy at the expense of speed, he is pretty convinced that the few mistakes he does make are not in fact errors at all. He then finds great difficulty in unlearning them. If he is to engage, then, in a method of discovery and building up of knowledge by the making of his own decisions, it is very important to guide his learning in such a way that he commits the minimum number of errors. He must be asked the right question at the right time. Secondly, he needs some automatic feed-back system to convince him that he *has made* an error. He is certainly unlikely to check for himself in a method where he has been allowed his own choice of response; he will be convinced that he was correct in the first place.

There are several other points which have arisen from experimental studies of adult learning. For example, it has been established that a middle-aged man finds it difficult to be “paced” in learning, either by other trainees or by the fixed speed of a machine or production system. This is perhaps a further reason why he progresses faster when he is allowed to structure his own learning during a fairly long session, and why in using industrial timers he does so well in beating his own target, but not so well when attempting to beat others. He is, too, often hampered by lack of confidence. Not only has the older man a fear of new machines, he also has a fear of new jobs and of new learning situations. There is often a marked reluctance to

commence training for fear that his previous standards will not be attained on new work. The slightest reverse will depress him disproportionately. The 40 plus needs both greater motivation and more self-confidence than does the 14 plus in order to make the learning situation a satisfying one, and unless he finds it so, he is unlikely to learn. He may, too, be damned from the start, if it is not realized that because of a slowing in perception he will less readily grasp initial instructions.

The problems surrounding change of job in middle age have not excited a great deal of interest in the past. For most people occupational mobility after 40 has been regarded as something exceptional. The circumstances in which the matter has been discussed have usually been those relating to special regions which have been hard hit by the decline of a traditional industry. But if Britain is to take up the challenge on a national scale, then it will be necessary not only to provide a background of security against which this may be done, but also a system of training which is geared to the special requirements of the older learner. Much has been learned from recent research about the psychological problems of ageing but little has been applied in practice.

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Legislation Aids Mentally Restored

Nevada has become the first state to pass a law setting up a special program of hiring the mentally restored for jobs in the state civil service. The program calls for temporary, limited appointments not to exceed 700 hours — an arrangement identical to the federal governments' hiring program for former mental patients.

As in the case of the federal program, this temporary hiring plan opens the doors to a mental patient's first job giving him possession of a work certificate and not just a hospitalization record.

The Atkinson Charitable Foundation 1964

The Atkinson Charitable Foundation, during 1964, distributed \$805,795.15 in support of 94 new and eight continuing charitable undertakings within the Province of Ontario. In our Summer 1964 issue, we told you of some of these grants that were of concern to people interested in the care and training of disabled persons. These included the grants to the audiology and training unit for infants and young children at the Hospital for Sick Children in Toronto, the grant to the Amity Rehabilitation Centre in Hamilton, Ontario, for the purchase of two trucks to be used in its collections of used clothing and furniture for processing in its workshop, the grant to the North Waterloo Society for Crippled Children to purchase a bus to transport children to and from the Society's treatment centre, the grant to the Victorian Order of Nurses to assist nurses to take post-graduate training and public health nursing, the grant to the Stothers Exceptional Child Foundation, Toronto to provide help for visually handicapped children, and the grant to the Metro-Toronto Branch of the Canadian Mental Health Association to assist in providing camping for mental patients.

In addition to these grants, the Foundation has provided \$42,725 to the Toronto Mental Health Clinic to be used to equip the first psychiatric hospital in Canada to be used exclusively for the treatment of adolescents. The new million dollar institution, to be located in downtown Toronto, will combine in-patient psychiatric treatment with day care and out-patient service, and, according to Dr. Angus Hood, clinic director, will, it is hoped, be the first of a chain of similar psychiatric hospitals for teenagers developed across Canada. This unique hospital will provide complete care programs including individual, group, and family psychotherapy, play-therapy, and drug treatment. In addition, schooling and recreational programs will be provided for both in-patients and day care patients.

A grant of \$7,137 to Saint Joseph's Hospital, Toronto, will provide equipment to support a research study being undertaken by Dr. Maurice Shusterman, concerning the retinal detachment of the eye and detection of this cause of blindness. Doctor Shusterman, in his planned research, is seeking to detect retinal holes in the early stages and treat them with artificial light therapy before blindness from retinal detachment occurs.

With financial backing from the Foundation, a summer clinic for children with impaired speech was instituted at the Rehabilitation Medicine division of the University of Toronto medical school. A 1964 grant of \$20,800 will enable the clinic to expand its program for these handicapped youngsters. During 1964, 143 children were assessed prior to the opening of the summer clinic and, from these, 33 were chosen for intensive treatment. Parents too were invited to the clinic where they received professional counselling, individually, and in group therapy sessions. In assessing the first year, Dr. Jousse, clinic director, said that while it is impossible to determine, at this time, the ultimate results of treatment in all cases, it is gratifying to observe the number of children who were substantially helped by the program.

A grant of \$5,345 to the North Waterloo Society for Crippled Children enabled the centre to purchase hydro-therapy equipment for the nursery school and a specially designed bus to transport handicapped children.

Needy deaf children again shared a \$3,000 gift to the Canadian Hearing Society. This grant brings to \$21,016 aid given to the Society with previous grants earmarked for purchase of hearing aids for children and for testing equipment.

A \$12,000 grant, authorized late in 1963, was paid in 1964 to the International Institute of Metro-Toronto. This grant is in support of a vocational guidance program directed towards the retraining of new Canadians handicapped because of language difficulties.

People and Events

Harold Russell Receives New Appointment

Harold Russell of Wayland, Massachusetts, Chairman of the President's Committee on Employment of the Handicapped, has been appointed to the National Advisory Council on Rehabilitation in the United States.

Mr. Russell will be remembered for his role of Homer Parish in the film "The Best Years of Our Lives" for which he received an Academy award. He lost both hands in a training accident while serving as a paratroop instructor during World War II.

Mr. Russell has travelled throughout the world in the interests of rehabilitation. He worked with the World Veterans' Federation for the Rehabilitation of victims of war and persecution.

It is hoped that Mr. Russell will be able to remain for at least a brief visit when he comes to Toronto in August to address the 68th Convention of the Fraternal Order of Eagles. Mr. Russell was born in Sydney, Nova Scotia, but has lived in the United States since early childhood.

John A. Nesbitt Appointed Assistant Secretary General of ISRD

The International Society for Rehabilitation of the Disabled has announced the appointment of John A. Nesbitt as Assistant Secretary-General of the Society. Mr. Nesbitt, who at one time was Secretary of the World Commission on Vocational Rehabilitation, will be welcomed back to the ranks of workers in the international rehabilitation field.

Dr. Moineau Joins Staff of Medical Rehabilitation Division

Dr. André Moineau, who received the Donald T. Fraser memorial medal for 1964 on completion of his D.P.H. training at the School of Hygiene, University of Toronto, has joined the staff of Medical Rehabilitation Division, Department of National Health and Welfare.

OTRC Appoints Assistant Executive Director

Mrs. Ellen M. Sabloff has been appointed Assistant Executive Director of the Occupational Therapy and Rehabilitation Centre in Montreal. A graduate of Queen's College, New York, Mrs. Sabloff has held the position of Supervisor of the Speech Therapy Department at the Centre since October, 1952, and for many years was on the staff of the Speech Department of the Montreal Children's Hospital. She is a member of the Quebec Speech and Hearing Society, and of the American Speech and Hearing Association.

New Director Forest Hill Rehabilitation Centre

Dr. David Hall Brooks of Ottawa has been appointed medical director of New Brunswick's Forest Hill Rehabilitation Centre replacing Dr. Lynn E. Bashow who has become Director of Rehabilitation at the Glenrose Provincial General Hospital in Edmonton, Alberta.

Dr. Hall Brooks is an experienced physiatrist and has been president of the Ontario Branch of the Canadian Association of Physical Medicine and Rehabilitation, and Chairman of the physical medicine and rehabilitation section of the Ontario Medical Association.

A Very Special Queen's Scout

Delmar Lafave, eighteen-year-old member of the 1st Ontario Hospital Boy Scout Troop at Smiths Falls, helped celebrate the 10th anniversary of his troop by becoming a Queen's Scout on February 10. He is the third member of this troop, made up entirely of retarded boys, to have achieved this award. Presentation was made by Dr. H. F. Frank, superintendent of the hospital, in front of his fellow Scouts, the Girl Guide company and many visitors. Clifford Bennett and Joe Fellows, both members of the school staff are the Scoutmaster and assistant Scoutmaster respectively. The Smiths Falls school was the first institution for the retarded to adopt Scouting as part of its training and therapy. It has now spread to twenty-two schools for the retarded across Canada.

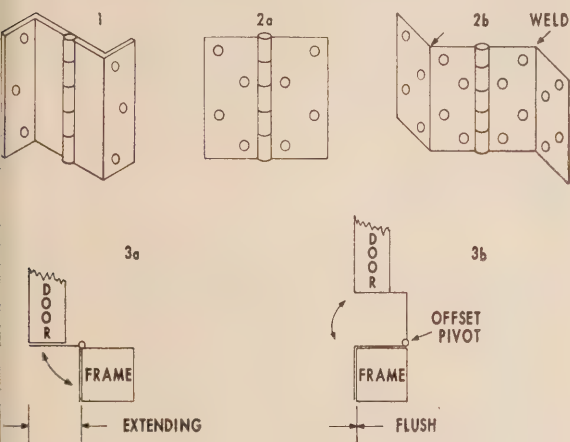
(The Phoenix, April, 1965.)

A Hint for Wheelchair Users

In his book "Designing for the Disabled", Selwyn Goldsmith says: "Wheelchairs are liable to conflict with the edge of the door frame adjoining the hinge; to minimize damage or where width is restricted, cranked hinges may be used.

"In alteration work, the provision of cranked hinges in place of existing butt hinges may obviate the necessity for dismantling the door and rebuilding with a wider opening (figure 1)."

In the "Idea of the Month" column in "Paraplegia News", September, 1964, Miss Nadine Pence of San Jose, California, shows how a pair of such hinges may be made from the ordinary article. Four are required to make the two special



ones; plates from two hinges are welded to the two to be used on the door. Figures 2(a) and (b) show the regular hinge and the newly designed one. Figures 3(a) and (b) contrast the operation of the regular hinge with the special one when applied to the door.

Mentally Retarded Trainees Commended

In February, the Opportunity Workshop, operated by the London and District Association for the Mentally Retarded, was presented with a proficiency award by the Northern Electric Company. The award was given for five years' work by the trainees who, during that period, packaged five million envelopes of telephone components for the company — a subsidiary of the Bell Telephone Company of Canada. As a memento of the occasion each trainee received a silver dollar.

Vocational Rehabilitation Centre, Toronto

The Jewish Vocational Service has consolidated its vocational rehabilitation activities into a new administrative unit to be known as the Vocational Rehabilitation Centre of Metropolitan Toronto. The Centre will operate as a division of the Jewish Vocational Service under the direction of Milton Friedman, J.V.S. executive director.

The new Centre encompasses three major rehabilitation facilities:

1. The JVS Rehabilitation Workshop which concentrates on preparing convalescent mental patients for regular employment.
2. The JVS Special Service Rehabilitation Unit which is engaged in a pioneering effort to re-establish chronic welfare dependents.
3. The JVS Sheltered Workshop, operated in co-operation with the Jewish Home for the Aged, which provides meaningful daily activities for residents of the Home.

The JVS opened its first workshop in 1956 with a daily capacity of 10 persons. Now it assists 75 persons daily, providing a combination of individual counselling and paid work under controlled conditions designed to make the handicapped employable in competitive industry. Since 1956, nearly 1,000 persons have been aided.

It is hoped that this new development will provide a suitable framework for further expansion of JVS rehabilitation services.

Financial assistance has been provided by the Federal-Provincial Vocational Rehabilitation program and the Laidlaw Foundation.

A New Film on

Scouting With The Handicapped

"Les Trois Victoires d'Enfants Uniques" is the title of a new film on Scouting with the handicapped. It runs about 30 minutes, has an English commentary telling of activities of handicapped French Scouts and Guides and is available, free of charge, from the Embassy of France, 42 Sussex Drive, Ottawa, Ontario.

(The Phoenix, April, 1965.)

Diabetic Detection Survey in Newfoundland

During the summer of 1964, the motor vessel "Christmas Seal" carried out its yearly medical survey along the coast of Newfoundland — on this occasion with added responsibilities.

In recent years, with the assistance of the Newfoundland Tuberculosis Association, programs of diabetic detection and location of handicapped persons have been added to what was originally a T.B. survey.

The 1964 program was conducted in coastal areas where no diabetic survey had ever been made before. During the summer, technicians aboard the vessel made 3,882 tests, met 68 known diabetics and contacted 54 suspects.

Advice is provided to known diabetics; suspected cases are reported to the nearest medical authority; and the persons concerned are advised to visit their doctors as soon as possible.

The 10th World Congress of the International Society for Rehabilitation of the Disabled to be held at Wiesbaden, Germany, September 11 to 17, 1966, will be an outstanding event in the rehabilitation calendar.

Both participants and organizers are confident that discussions on the overall Congress theme "The Industrial Society and Rehabilitation: Problems and Solutions", will provide a survey of the present state of rehabilitation and produce many new ideas. The sessions should furnish opportunities for intensive exchanges of ideas and afford all participants the means of perfecting their professional activities in the cause of rehabilitation. Above all, the Congress aims at finding ways to improve job placement and rehabilitation programs for the countless handicapped, disabled and sick throughout the world. In conjunction with the Congress, there will be an international film theatre and an international educational and industrial exhibition. These will serve to illustrate different aspects and problems in the field of rehabilitation and to elaborate on the theme of the Congress.

Practical Nurses Trained in Rehabilitation Nursing

An in-service education program for licensed practical nurses was begun at the Manitoba Rehabilitation Hospital on February 15. The program involved 15 practical nurses each of whom received a minimum of 37 hours of instruction in the art of rehabilitation nursing.

The lectures and practice sessions were held for one hour daily at the hospital. Mrs. M. R. Trainor, nursing instructor, was in charge of the program. Special lecturers included Miss E. L. M. Thorpe, Sanatorium Board nursing consultant, Miss V. R. Peacock, M. R. H. day supervisor, Miss Jean Alexander, S. B. M. assistant director of dietary services, Miss Marie Damen, speech therapist, James Foort, technical director and Dr. R. R. P. Hayer, physical medicine consultant.

New Books

Home Care for the Mentally Retarded

Part I — Its Meaning and Importance

Part II — A Manual for Committees

Prepared by Jacqueline Cummiskey, Home Care Consultant for the Canadian Association for Retarded Children, 87 Bedford Road, Toronto 5. Price \$1.00 per set.

This guide was developed from the findings and experiences of the Home Care Project conducted by the Canadian Association for Retarded Children — a project financed in part by the Department of National Health and Welfare.

The first of the two booklets discusses the changing philosophy of the care of retarded children and outlines the different types of care they require. It discusses the role of parents and their need for community support and outlines the various community programs needed to ensure that families with retarded persons are able to meet the demands made upon them.

The second booklet gives direction to local associations planning home care programs and offers practical suggestions to committees.

Special Problems in the Vocational Rehabilitation of the Mentally Retarded

This is the report of a conference sponsored by the University of Wisconsin and supported by the Vocational Rehabilitation Administration of the United States Department of Health, Education and Welfare. The participants were distinguished professional workers in the fields of mental retardation and vocational rehabilitation and their purpose was to establish practical guides applicable to selection, counselling, training and placement of mentally retarded individuals. The report includes an annotated bibliography of reference material dealing with these areas of rehabilitation.

Limited supplies of the report are available for free distribution and requests should be sent to the Chief, Division of Disability Services, Vocational Rehabilitation Administration, Department of Health, Education and Welfare, Washington, D.C.

Amputation - -

Ask The Man Who Has One

National Civilian Liaison Committee, the War Amputations of Canada, 140 Merton Street, Toronto, Ontario.

This booklet provides information regarding the amputation itself, after-care of the stump and provision of the prosthesis.

A Civilian Liaison Program was established by the War Amputations of Canada to extend the facilities of the association in the fields of rehabilitation and training to civilian amputees.

Under this program four services are provided as follows:

- (1) An advisory service for persons who have been warned of the necessity for amputation;

- (2) An advisory service during the post-operative period for persons who have undergone amputation;
- (3) An advisory service for the family and relatives of an amputee; and
- (4) Information and demonstrations concerning the best types of orthopaedic appliances, based on data gathered by the Prosthetics Committee of the Association.

A member of this association is prepared to visit a potential or actual amputee to provide advice, encouragement or other help.

The booklet has been developed as part of this program and copies may be obtained from local branches of the Association.

(continued from page 10)

of nerves and muscles. The hospital has good laboratory equipment for investigation of this nature but at present lacks the people to carry out research.

Technical Committee

The Directing and Advisory Technical Committee will be responsible for establishing regulations and for supervising and reviewing projects.

Present members are: Dr. Truelove; Dr. M. C. Blanchaer, professor and head of the Department of Biochemistry, University of Manitoba School of Medicine; Dr. M. G. Saunders, associate professor of physiology at the University of Manitoba and head of the Department of Clinical Physiology at the Manitoba Rehabilitation Hospital; and Dr. A. H. Shephard, professor and head of the Department of Psychology, University of Manitoba.

Reprinted from News Bulletin, The Sanatorium Board of Manitoba, February 1965.

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Provincial Co-ordinator of Rehabilitation,
Department of Public Welfare,
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Department of Health Service and Hospital Insurance,
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VANCOUVER 9, British Columbia.

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Rehabilitation **IN CANADA**



published in the interests of Canada's Disabled by ...

CIVILIAN REHABILITATION

Department of Labour Canada



**FOR
ABILITY**
HIRE THE HANDICAPPED

To Our Readers

Did you know that there are about 6,000 paraplegics in Canada and some 30 new cases each month?

A recent survey of paraplegics under treatment at the Nova Scotia Rehabilitation Centre showed that ninety-two per cent had become paraplegic, or quadriplegic, as a result of accidents. Of these, fifty-four per cent were involved in automobile accidents, which resulted in three times as many quadriplegics as paraplegics; fifteen per cent had suffered swimming mishaps, and tractor accidents turned eight per cent into wheelchair farmers.

Percentages in these categories vary, of course, from one region to another, but the significant fact is that the majority of paraplegia cases are caused by accident and not disease as was formerly the case.

Nineteen sixty-five marks the 20th anniversary of the founding of the Canadian Paraplegic Association which had its origin in the plight of the paraplegic war veteran. Today it is the accident victim that challenges the Association to new heights of endeavour.

Although the primary cause of paraplegia has changed, the basic needs of the individual remain the same and the Association strives to secure for him acceptance by the community, help in obtaining employment, suitable living accommodation and means of transportation.

The Association is spearheading a campaign for removal of architectural obstacles in public buildings and business establishments, and in many areas in conducting a comprehensive program of surveys and public education.

The Association in co-operation with the Canadian Highway Safety Council, and other agencies, is also engaged in an all-out preventive program to educate the public in the safe and sane use of our highways and thus strike at paraplegia's principal source — the automobile accident. Statistics illustrate with tragic clarity the need for active support of this program and few will be more acutely aware of this need than our readers.

In all aspects of our daily lives, whether on the highways, at work or at home, strict observance of safety rules offers the only hope of reducing the needless waste of human lives and resources.

CONTENTS

Page

- 4 The Present Status of Myo-Electric Control Systems in Patient Rehabilitation
- 8 Building Standards for the Handicapped
- 9 The Normality of Exceptional Children
- 15 Paraplegic Unit — Six Big Steps to Recovery
- 19 Housing and Special Accommodation for the Handicapped
- 20 The Mental Retardate — His Problems and Actions
- 23 Harold Russell Speaks on Employment of the Handicapped
- 25 Training Older Workers in New Skills
- 27 Special Services Rehabilitation Unit
- 28 People and Events
- 31 New Books

This bulletin is prepared by Civilian Rehabilitation, Department of Labour, with the co-operation of the Department of National Health and Welfare, the Department of Veterans Affairs, the National Employment Service and governmental and private agencies interested in the rehabilitation of Canada's disabled.

DEPARTMENT OF LABOUR, CANADA

Hon. Allan J. MacEachen
Minister

George V. Haythorne
Deputy Minister

The Present Status of Myo-Electric Control Systems in Patient Rehabilitation

A paper presented at the Atlantic Region Medical Engineering Symposium, Dalhousie University, Halifax, on May 27, 1965 by R. N. Scott, Associate Professor of Electrical Engineering, University of New Brunswick.

Any control system may be considered to be composed of at least three essential elements: the operator, who does the controlling; a machine, which is controlled; and an equipment between the man and the machine which, in general, transmits information in both directions between the man and the machine, and suitably modifies this information so that it is useful to the receiver. In all normal control system of which I am aware, information is obtained from the human operator in the form of physical movement produced by skeletal muscles. For example, one of the many control systems involved in driving an automobile consists of the driver, a so-called accelerator peddle which is adjusted by physical motion of the driver's foot, and which through appropriate linkages controls the throttle of the engine.

The subject of this paper is myo-electric control. A myo-electric control system is one in which the electric potentials accompanying the voluntary contraction of human muscle are used as the output information from the human operator. Whether any observable motion of body members results from the muscle contraction in such a control system is unimportant. A very significant concept, basic to the whole theory of myo-electric control systems, should be noted at this point. Whereas, in the normal system it is required that the operator be capable of controlling the physical movement of a certain part of his body, in a myo-electric control system it is imperative that the human operator be capable

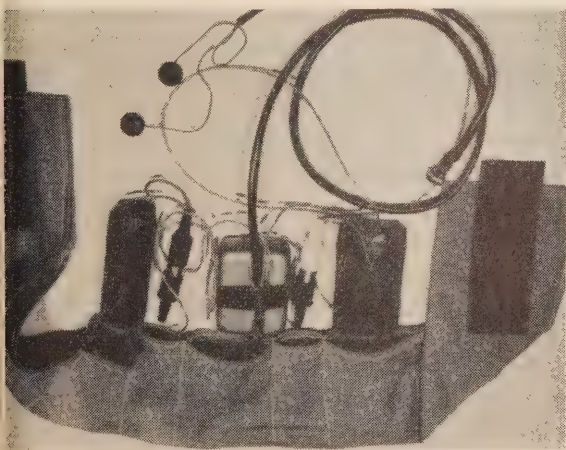
of controlling the myo-electric potentials in a certain muscle.

At the present time, man has available to him a considerable variety of conventional or manual control systems, which will accomplish almost any purpose. It is important then to ask why there is a need for a myo-electric control system. There are really two answers to this question. It is generally a good thing to have as many alternatives available for the solution of a given problem as possible. If this is true, then it is useful to make available an alternative to manual control. The other and much more significant justification concerns the large number of persons who, through physical disability of one form or another, are incapable of operating normal or manual control systems. The extent to which these persons can control the various aspects of their environment, and can become or remain productive in our modern society, could be greatly enhanced were there a practical alternative to manual control systems.

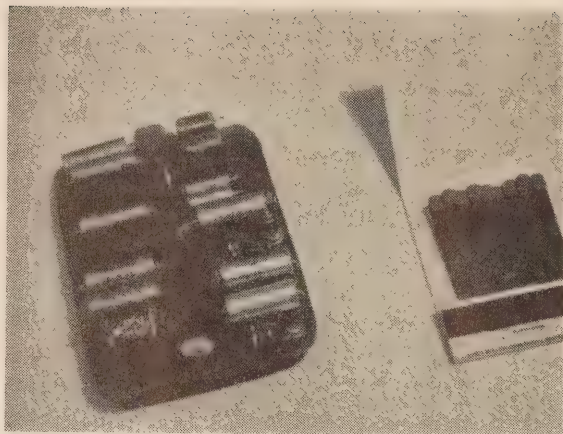
In physical rehabilitation there are three important applications of myo-electric control. It may be used to provide, for a traumatic or congenital amputee, a means of controlling a prosthetic terminal device, using the muscles in the stump as control sites. In this application, essentially "normal" muscles which would otherwise serve no useful function are being used as control sites. Myo-electric control may be used to operate powered orthotic appliances to supplement the capability of partially denervated or

otherwise weak muscles. For instance, an arm-aid for a quadriplegic could be controlled by the myo-electric output of the patient's biceps brachii, even though the mechanical output of that muscle were insufficient to accomplish useful work. Finally, myo-electric control systems may use normal muscles as control sites, even though there is no modification of the normal usefulness of those muscles. This involves retraining of the patient, and is restrictive of the patient's activities. However, in the case of certain severe disabilities, it may be useful. For instance, a patient with the complete loss of both upper limbs, either from traumatic amputation or as a result of a congenital abnormality, may prefer to sit quietly and use the muscles of the thigh to control artificial arms and hands, in preference to eating with his feet.

There are three chief problems in the practical utilization of myo-electric control systems. The first results directly from the design of the human body, in that no convenient terminals are provided thereon at which to measure the electric activity of muscles. Rather, some form of electrode or transducer must be affixed to the body, either internally by surgical techniques, percutaneously, or superficially. At the present time, I feel quite safe in saying that no satisfactory electrode system exists from chronic application



The three-state myo-electric control system as fitted in the initial clinical trials. The two surface electrodes are shown at the upper left, and below, from left to right, the motor battery, control unit and control unit battery with the belt which was used as a temporary support pending design of a more suitable harness.



The control unit before packaging. Completely assembled this unit weighs less than one-half pound.

in myo-electric control. However, various surface electrodes have been developed recently, (1, 2), which show considerable promise if means can be found to hold them in place without the use of adhesives. We have developed a form of percutaneous electrode, (3, 4, 5), which will be quite satisfactory for long term application provided that an improved method of attachment to the electrode outside the skin is developed. The development of implantable transmitters at the Case Institute of Technology, (6), is encouraging, although the necessarily high cost of wireless telemetering equipment is a deterrent to its use in multi-channel systems. One can say, with respect to the problem of electrodes, that at the present time electrodes are available which can be used with reasonable performance, although not with the degree of convenience and reliability which is to be desired.

The second problem concerns signal processing. Basically, the question is this. Having obtained a myo-electric signal at the external control equipment, what property of that signal should determine the response of the electro-mechanical output unit, and how should this property be measured? The requirement here is that some property of the myo-electric signal over which the patient can best exert voluntary control should be chosen. Unfortunately, few if any valid comparative measurements of operator performance using different characteristics of the myo-electric signal have been carried out.

The predominant trend is merely to rectify the myo-electric signal and smooth it with a low pass filter, making the system response dependent upon the time average value of the rectified waveform. An alternative which has been used fairly frequently is the time rate of crossing of an arbitrary non-zero threshold potential. There are also questions concerning the optimum manner in which to utilize signals from more than one muscle, and perhaps these questions also lie in the area of signal processing. While most workers express a preference for the system in which each muscle is associated with a specific function of the output unit, some work is being carried out by the Philco Corporation, (7), in respect of pattern recognition systems. These systems are intended to recognize a pattern of myo-electric activity involving several muscles. Each output function would be controlled by a different, recognizable pattern of activity of the various muscles. While it is somewhat important, especially in providing control systems for ambulatory patients, that the electronic control equipment be very small, at the present state of the art this does not present any major obstacle. Briefly, the problem in signal processing is not how to accomplish the processing, but what processing to do in order to obtain optimum performance.

The third problem of importance is the lack of suitable electro-mechanical output units. At the present time, the only electrically powered prosthetic appliance available in Canada is a hook developed by Mr. Colin McLaurin at the Toronto Crippled Children's Centre. This unit has only recently become available, and is certainly very welcome. We understand that powered wrist and elbow units are nearing completion at the same centre, and if the quality of these units approaches that of the hook the lack of adequate output devices will soon cease to be a major obstacle. One can always use myo-electric control in the more conventional and widely available systems powered by compressed gas. However, in that case it is necessary to employ a solenoid valve, and currently available solenoid valves are extremely inefficient. At any event, it is probably preferable to have an all

electric system, assuming that adequate components are available.

The present state of development of myo-electric control systems can be summarized rather briefly, and can best be discussed in geographic terms. Work in the United States of America has not generally been directly intended to produce equipment for use by patients. Most of the research there has been directed more toward the acquisition of knowledge. An exception is the development of an electrophysiologic splint, (8). This is a system in which the myo-electric signal from one muscle is used to control the electric stimulation of a second (paralyzed) muscle, in order to produce movement of a limb. The most advanced work in England is probably that being carried out by Bottomley, (9). He has developed a myo-electric control system which gives proportional control of the force exerted by a terminal hook. This system is at present in the laboratory prototype stage, but is, we understand, now undergoing development with a view to manufacture.

The only myo-electric system which is in use by patients, to our knowledge, is that developed by Kobrinsky, (10), in Russia. This much publicized system is an on-off control, which uses contraction of the flexor muscles in the forearm to control closing of a terminal appliance, and contraction of the extensor muscles to control opening of the appliance. It is designed for use by a below elbow amputee. The terminal device made available with this prosthesis is a cosmetic hand which provides the normal chuck type of prehension. The primary defects of this system are poor reliability of the electronic components, the necessity of providing a relatively large myo-electric signal for actuation of the terminal device, the need for two muscles to control the single terminal device, and, chiefly, its limited availability. While this system has been fitted to more than 100 patients in Russia, and while the rights to purchase or manufacture this equipment have been purchased by organizations in England and in Canada, it is still not generally available to patients. In Canada, the rights to the Russian appliance have been purchased by the Rehabilitation Institute of Montreal, and certain clinical trials are being made there.

We have recently been able to demonstrate the first all Canadian myo-electric control system, using Mr. McLaurin's electric hook as the output device. This system uses one muscle to control two functions, and has been labelled a three state myo-electric control system. A small contraction of the controlling muscle activates one relay. A somewhat stronger contraction of the muscle activates a second relay, and returns the first to its normal position. This is, then, an on-off system. It does not require a very large myo-electric signal, is reasonably compact, will control any electrically-powered terminal device, and, most important, this system will be made available for research purposes and clinical applications in the very near future.

To summarize, myo-electric control systems for use by the physically handicapped are just now emerging from the laboratory to become useful and practical in the rehabilitation of patients. We can confidently predict that the next decade will see significant advances in the design of these systems. They will be adopted more and more frequently for the control of prosthetic and orthotic appliances. They will never supplant mechanical control of these appliances, but will, we hope, be used to supplement mechanical control when the patient cannot use mechanical control for a sufficient number of functions.

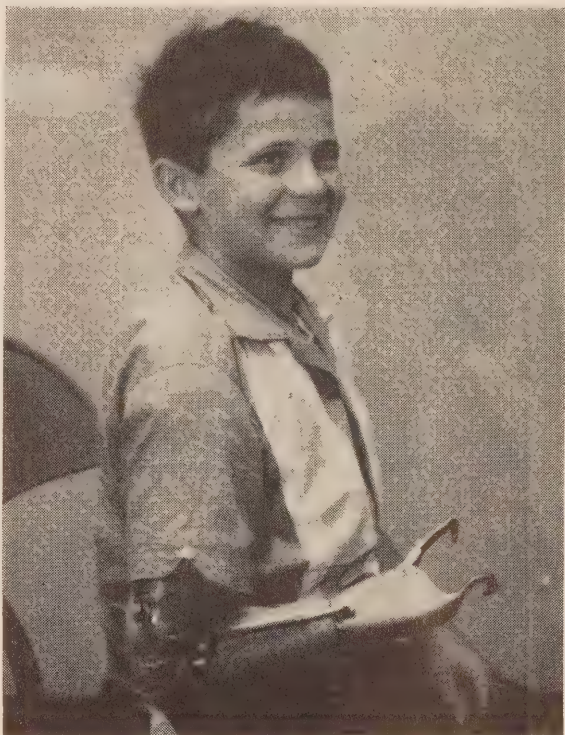
It is to be hoped that we shall gradually overcome our inclination to keep new developments too long in the laboratory, in the hope of achieving perfection. We can benefit significantly from the example of the Soviet Union, in the matter of making available, to the patients, the results of our research, even though these results are not perfect.

ACKNOWLEDGEMENT

This research is supported chiefly by a Public Health Research Grant from the Department of National Health and Welfare, with additional support from the National Research Council, the New Brunswick Research and Productivity Council, and the New Brunswick Co-ordinating Council for the Handicapped.

NOTE

After this paper was presented, the first clinical trial of the three-state myo-electric control system was carried out in co-operation with the Ontario Crippled Children's Centre. The patient was Paul Picard, of North Bay, Ontario, an 11 year-old above-elbow amputee. The biceps brachii muscle in the patient's stump was used to provide voluntary opening and voluntary closing of the electric hook.



Paul Picard wearing the three-state myo-electric control and the electric hook developed at the Ontario Crippled Children's Centre in Toronto.

Initial results of the experiment are very encouraging. The patient learned to use the control system in a matter of minutes, and is pleased with its performance. The chief defect in the electronic control is sensitivity to electrical interference, and this problem is being carefully studied with the expectation of a minor modification to correct it.

Additional control systems are being made available immediately for evaluation by various centres in Canada and abroad.

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BUILDING STANDARDS FOR THE HANDICAPPED

Earlier this year the National Research Council's associate committee on Building Standards for the Handicapped issued Supplement No. 7 to the National Building Code of Canada which is called "Building Standards for the Handicapped 1965."

Since the issue of this supplement in the Spring of this year, federal and provincial rehabilitation authorities ably assisted by voluntary agencies have been actively engaged in publicizing it, and urging the adoption of its standards in all public buildings in Canada. It has been widely distributed among architects, architectural associations, federal and provincial government departments, municipal authorities, voluntary agencies and other organizations concerned with public buildings.

Considerable interest has been shown in the Supplement. Several organizations have announced their intention to survey public buildings in their community for accessibility to the handicapped. In fact a survey of over 800 public buildings in Winnipeg is now being conducted by the Canadian Paraplegic Association.

We enclose in this issue of "Rehabilitation in Canada" a copy of the pamphlet "Opening Doors". This pamphlet serves to introduce Supplement No. 7 and is intended for wide distribution. It is available in quantity on request from your provincial co-ordinator of rehabilitation or directly from Civilian Rehabilitation Branch, Department of Labour, Ottawa, to any organization or group who would like to assist in publicizing these standards and encouraging their eventual adoption in their own community.

The Normality of Exceptional Children

BY L. P. PATTERSON, M.A., ED.D., F.C.C.T.,
School for Crippled Children, Montreal

The writing of this paper has been attempted with the possibility of two results in mind (1) the development of the theme that exceptional children, once their disability has been provided for — and that is often a major undertaking — are very much the same as other children and (2) the encouragement of the trend to accept more and more exceptional children into the regular classroom. I cannot help but feel that, due to lack of information or perhaps the acceptance of some misinformation, teachers as a group tend to exaggerate the deficiencies of these children and hence resist any suggestion that they enter the regular classroom.

Dick and Jane are brother and sister. Dick had poliomyelitis and one leg does not function properly. Jane has acne. Of their cousins Bill is a haemophiliac; Susie's father is an alcoholic; Craig has cerebral palsy. Wendy, who lives next door, rarely sees both parents at once and, when they are at home, they fight. The doctor's son down the street wants to own a hardware store but his father insists that he follow the family tradition. Robert has an I.Q. of 165. His sister's I.Q. is 80.

Which of these children are handicapped?

My answer is that they all are and that these handicaps are more common than we realize. Furthermore it really serves no useful purpose to try to arrange them in some order of relative disability, for all of these children have problems which need attention and solution.

We can and should extend this answer to say that all children and all adults have their handicaps, many of them remedial. Although the older you get the less remedial they are, for many of us

senior citizens enjoy poor health be it physical, mental, or emotional.

We can start then with two fundamental propositions: all exceptional children are essentially normal; all normal children are exceptional in some respects, i.e. are handicapped in some way.

If we accept these statements as true, we have certain considerations which should be examined.

1. *What are the elements which make a child exceptional; which distinguish him from other children?*
2. *How can we discover and measure these elements?*
3. *What modifications do we need in our educational process which will overcome these handicaps as far as possible?*
4. *Should we encourage the process of turning us all into one great mass of perfection?*
5. *Do our curricula and teaching methods tend to overcome handicaps, ignore them, or magnify them?*
6. *What do our normal schools do to train teachers to recognize and overcome handicapping conditions?*

Let us classify some of the major divisions of exceptionality. Let me say here that I am excluding any discussion of geniuses or the very bright child. They are exceptional. There is no question about that. And they have their major problems, more serious is their effect upon society in many respects than the others I will discuss, for they have greater power. But the term "exceptional" is essentially a euphemism and I feel uneasy in its use in this area for the application here is more forced than for the other types.

Another good reason for excluding them is that it is always safer to talk about people who are not present, and by hiding behind this restriction, I can avoid discussing the component elements of this august meeting.

We then have five major divisions and one overall category. It is quite possible that some one else would probably have a different classification:

- A. the deaf
- B. the blind
- C. the mentally retarded
- D. the emotionally disturbed
- E. the physically handicapped which may be further subdivided by their disability: e.g.
 - a. Muscular dystrophy
 - b. Poliomyelitis
 - c. Rheumatoid arthritis
 - d. Cardiac problems
 - e. Haemophilia
 - f. Legge-Perthes disease
 - g. Congenital deformities
 - h. Cerebral Palsy
 - i. Epilepsy
 - j. Spina Bifida
 - k. Many others
- F. The multiply handicapped who may have any combination of any two or more of the above.

A. The Deaf

Before I became associated with my present work I knew what deafness was. It was simple. You couldn't hear. Now I am not so sure, for it is a vastly complicated situation. There are different reasons for deafness each with a different treatment. You may hear low notes but not high, or the reverse, or in different amount. One ear may be quite different from the other in its response to sound. And again you may have any combination of the above. May I give one generality: few people are completely deaf.

There are certain things that all educators should know about deafness.

First of all, it is probably the worst of all handicaps. Most of us would probably prefer to be deaf than blind, but I would remind you of two things: (1) blind people can do nearly everything that a sighted person can; (2) communication is a most essential part of our social, vocational, avocational and emotional life. Blind people can communicate normally. It is a major problem with the deaf. Authorities in the field tell me that the deaf tend to become suspicious; have great difficulty in getting jobs; and great difficulty in keeping them. These people are not inherently suspicious nor difficult. Their handicap is ever present and to overcome the frustrations caused by it presents a continual struggle. The number who do win this battle is cause for satisfaction and wonder. The minority who can't quite make it need further help not pity.

The other matter which I bring to your attention as educators is a silly and almost criminal argument which has been going on in deaf circles for centuries and seems to be so deep rooted in emotional undertones that a meeting of minds and a logical approach seems almost impossible.

I refer to the two methods of teaching the deaf: oral and signing. The advocates of both are fanatical. Both become emotional at the drop of a hat. It is an area in which you can get a plethora of opinion and very little evidence.

Finger spelling is the use of various positions of the fingers of one hand to designate the letters of the alphabet. We are all familiar with the hitch hiker who thumbs a ride. He is signing. It is not a language but certainly expresses and conveys meaning. Here is one area where there are no problems of bilingualism or biculturalism. There are I believe evidences of slang in signing and local modifications which identify the locality of origin of the deaf person but deaf people from all over the world can communicate with each other by this method.

Oralism is the use of lip-reading and speech. If accomplished, it approaches normality of communication, almost, and the most desirable end. There are always such factors as lighting, distance, formation of sounds by the lips — North Americans talk through their teeth — the fact that some sounds are not "visible" on the lips, some quite

dissimilar sounds "look" the same, all of which works against even the most expert of lip-readers. And then he has the most difficult problem of talking to you by making sounds which he cannot hear.

I do not see how it can be successfully argued that this is not the preferable of the two methods. What I strongly object to is the position that either method is the answer for all children.

What we need, and need badly, are three things: (1) research and scientific knowledge on the virtues and faults of these two approaches, not opinions, (2) an open mindedness and a meeting of minds on the part of teachers of the deaf, (3) a mutual agreement, one adhered to by all, to assess and continue assessing each child at proper intervals and to place that child in the teaching and learning situation which best matches his abilities and needs.

Of course this is but a special case of the general theorem that teachers must reinforce the slow trend in education to develop and modify methods and curricula to meet the needs of children, not try to modify the child to fit a single pattern.

B. The Blind

Here again we have a clear case of the necessity for different methods because of the disability. However the printing of text books in Braille and the co-operation of fine teachers in the classroom has meant that once these children have learned to read and write Braille, many of them can take their place in the classroom with other children with great success.

C. The Mentally Retarded

These and the emotionally disturbed are the "sunrise" areas in education. Long neglected they are now being accepted by society and the teaching profession not as a duty but as a group which rewards the constant and skilled efforts required. These children, if properly taught, can be turned into socially acceptable and self-supporting citizens. May I pay a tribute to the Kennedy family who have focused the attention of the world on the problem of the mentally retarded child. They have given it status and have awakened the social conscience to this most common disability.

D. The Physically Handicapped

These children present a great variety of problems, as their listed disabilities show, and they cut across all of the usual educational divisions of children. They include the gifted, the mentally retarded, and the average. They have the physical problems of their disability but in other respects have the same hopes, fears, desires, wants as other children.

The educational problems of these children seem to me to fall into two classes:

1. Those connected with the limitation of their disability. For example, a teacher should not allow a cardiac to be overtired. An athetoid cerebral palsied child has a major problem in learning to write, although learning may be normal. He may be deaf to high tones, as well. Posture, the fitting of the desk, the placing of feet on the floor, are all important. There should be a close co-operation between the teacher, the physiotherapist, the speech therapist, the occupational therapist, the nurse, and the doctor.

2. An intensification of the usual problems ordinarily found in the classroom and elsewhere rather than a difference in problem. My experience is that we and the regular school have the same problems but the problem is probably greater in degree in schools for exceptional children.

What are some of the reasons for this state of affairs?

1. Frustration

First of all, I would list the debilitating effects of continued frustration. We are all frustrated at times and some say that frustration now and then is good for character building. That may be, but I do know that frustration all of the time can be, and often is, destructive.

This is often shown in what we call being bad. For example, a child will sometimes kick another or otherwise hurt him. This is not necessarily intended as a sign of ill will. In fact, the recipient may be his best friend. It is not always a desire to hurt. It can be a way of releasing the tensions of frustration. It takes a wise teacher to tell when it is meanness and when it isn't, and to be understanding when it is meanness. The above is an

over-simplification but it is most important for teachers to be able to recognize the hidden reasons for some behavior and to know what to do and how to do it, to be able to obtain acceptance of a disability without giving in to it, for it is almost axiomatic that the child who is determined to conquer the limitations of his disability gets much closer to his goal than the child who tries only half-heartedly.

Physically disabled children have their frustrations, plenty of them, and sometimes their conduct shows it, but I come back to my original statement that the problem is not unusual. It is somewhat more serious. For all children have their frustrations which cause poor behaviour. The exceptional child has these too but he cannot get rid of them quite so easily and hence they build up.

2. *Parental Attitudes*

Too often, perhaps usually, and this is probably normal also, parents of physically disabled children tend either to spoil or reject them. The rejection may be either conscious or unconscious, but the results are the same. All children and adults need some love and a sense of security. The teacher often has the difficult role of foster parent but at the same time she must not get emotionally involved.

On the other hand, we have the equally bad or even worse situation where Johnny is allowed to do as he pleases because he is a cripple. This is very poor training for Johnny, who sooner or later will have to learn differently. Every teacher has to be prepared to give some pupils a little extra attention and to show others that the world does not, nor will it, revolve around them and it is better for this lesson to be taught wisely in the early grades than it is to learn it as an adult, for learn it one must.

3. *Lack of Prestige*

Prestige values change as we get older. There are probably not many to whom the desire to lower the world's record for the mile has any great appeal. We might like to be the title holder, but our realization that we are not likely to be that person, even if we gave it whole-hearted devotion, does not cast a pall over our lives. We drive

larger cars, we travel, we live in certain areas, we join colleges, we give papers.

In the life of a youngster physical exercise plays a most important prestige role. The ability to run faster, climb higher, kick farther, catch a ball better, gives a sense of satisfaction. The physically handicapped boy or girl can not excel in these areas, so he is denied a prestige role most important to him at a formative period of life. Is it not surprising that he will have a few psychological scars? It is our job, then, to substitute other goals, to see that he gets a sense of accomplishment in other ways. If we teach pupils so as to ensure even small successes instead of failing them, much of this problem can be overcome.

Having said these things and I am afraid over-emphasized some aspects to the point of creating an impression that these pupils are all psychological problems, I want to state categorically that they are essentially normal children with the troubles common to their brothers and sisters. These brothers and sisters have psychological problems too and they are sadly neglected in the regular classroom. Perhaps special education has the role of pioneer in this area so that in time psychological and psychiatric services will be extended to all who need them.

E. **The Multiply Handicapped**

This group, I am afraid, is growing in number both relatively and absolutely. Modern medicine is keeping children alive which a few years ago would have died. Some of these children with hereditary disabilities, of which there are quite a few, are living to adulthood and in turn having children, thus transmitting disease bearing genes into society. However, this may be a problem for sociologists and society at large, not teachers, so we will pass to the educational aspects.

General opinion is at the moment that the child should be taught in terms of his major handicap.

The difficulty is that it is often a real problem to decide just what the major handicap is. For example, what do you do with a cerebral palsied child who is mentally retarded and partially blind? There may be three institutions in the community,

each dealing with one phase of the total handicap, all good, but to which one should she be referred.

Perhaps the lessons to be learned are that there should be:

(1) A good diagnostic service so that the abilities and disabilities of the pupil can be all accurately assessed;

(2) A good relationship between the hospitals and the schools, for these children have both medical and educational problems which are inseparable, as each influences the other;

(3) A school for exceptional children where all types of special education are given. This would enable a child with several disabilities to obtain the various facilities he requires in the same school.

This brings up the question of mixing children of different disabilities in the same school. I have yet to note any problems among children who mix with others with different disabilities. In fact they help each other in a complementary manner, for someone can supply what another lacks. I know that many are against the idea but we need scientific evidence, not opinion. Perhaps it is the adults who are insecure.

I would not want to finish this discussion without bringing to your attention the problem of the relationship of the exceptional child to the regular school pattern.

Can we agree that, if a child can, he should go to the regular school? We may have either reasons or opinions to support the statement, but it seems to me that every child should follow the normal pattern, if possible. This is a corollary of Democracy: every one should enjoy the good things and suffer the limitations of the society of which he is a part. I put in the latter condition because it is not unknown for the special schools to be better in many ways than the regular schools in the same community.

But I maintain, and the reasons will be outlined below, that no matter where you draw the lines, there will always be children who need special facilities in order to obtain an education.

I am also happily of the opinion that more and more children with disabilities are being

accepted into the regular classroom and this acceptance also includes a greater severity in the disabilities which are being accepted.

Let us consider some of the factors which necessitate either a special school building or the allotment of one or more classrooms in a regular school to special education.

1. *The disability:* As has already been mentioned, the blind and deaf have to learn special techniques which cannot be taught in the regular classroom. Many of these children, but not all, will make the change to the regular classroom sooner or later, but the educational needs of the others still remain the responsibility of the state through a special school. The emotionally disturbed child can only be taught in maximum classes of one or two or three or four until his recovery is assured. The mentally retarded should not be in regular classes, although I am sure that many of them are. Whether they can become part of a regular schoolroom or not, I don't know, but I suspect that it depends a good deal on the amount of mental retardation.

2. *Special equipment:* Many physically disabled children could go to regular schools if the school were properly equipped with, for example, elevators, hand rails, wheelchairs, lunch facilities, rooms with cots for extra rest, special desks, toilet rails etc. To provide all of these things in every school is possible but economically unreasonable, unless the child would suffer in a special school. It would be difficult to uphold the thesis that special schools are inherently harmful. This will be discussed later.

3. *Transportation:* There are many children who have to be transported to school. It is cheaper to have a few buses running to a central location than to have a bus for each school.

4. *Medical and para-medical services:* In this term is included physiotherapy, occupational therapy, speech therapy, nursing and other medical services. These people all require space and expensive equipment, and most of them are a necessity in the building where the disabled child goes to school, which again confronts the taxpayer with an unrealistic economic approach, unless the services are centralized. Often these

services can be found in a central hospital or rehabilitation institute, but it is saving a pupil's time to have his treatment in his school than elsewhere, and education is his major responsibility. The more school he misses the more do his societal handicaps increase.

5. *Competition:* I believe in competition among peers, and I do not believe in over-protecting handicapped children. I do not believe that their best interests are served by placing them permanently in an inferior position. Is it not better to place them in an environment where competition among equals can be assured and where they can be gradually built up to face the rigours of the world?

The trend in educational circles today is to put all children in regular classes. I have seen these children in these classes and have come away with the feeling that they were not really a part of the full class work, and that there is no one more lonely than the boy or girl who is the only one who is different. After all, Democracy does not insist on uniformity. Its belief is in equal rights and equal opportunities and these can be found in special schools.

But all of these arguments are as naught if the special school harmed the child through its philosophy or unwittingly through segregation. I will say that a special school can be good or bad or in between, depending on its board, its administrative head and its staff. It is not inherently good or bad. It behoves us to see that these elements are good.

I would like to point out, and the point may otherwise be missed, that in a school for the physically disabled the faults of segregation do not easily gain ground. For there are so many varieties of disability that we get virtues of normality at a lower physical level. This seems paradoxical but the diversity inhibits any feeling that the pupils are special and need to be pitied.

Each pupil feels that he is better off than others and gains strength from this assurance. In fact they are a very happy group of youngsters.

As I close, my listeners may have noted that I have raised issues which have not been discussed. There are many questions to be answered and much to be learned here, as well as in general education. We need more refined diagnosis and assessment followed by more exact and excellent methods to suit the differences we have discovered and measured. We need the acceptance with equal prestige of different curricula. We need in Canada, centers of merit where teachers can be trained in special education. At present we have to go to the United States or import from across the Atlantic.

I would like to finish on a positive and enthusiastic note. In my fifteen years experience I have seen: special schools open their doors, more and more exceptional children go to regular schools, fewer and fewer parents hiding their disabled children, more school boards accepting their responsibilities for these children, more efforts being made to develop courses by which these children can profit. It is altogether an optimistic record, although much still needs to be done.

I would ask you, then, as members and fellows of the College, to find out what special resources there are in your community. If there is none, work for the establishment of a special school. If there are existing schools or classes, visit them and support their efforts for they will need and appreciate your help. You will find a happy group of youngsters needing special techniques, it is true, but fundamentally the same as other children. If we provide them with suitable curricula and good teachers they will pay for the cost of their education many times over by becoming self-supporting citizens, not wards of the state.

This paper was delivered at the Eighth Annual Meeting of the Canadian College of Teachers at St. John's, Newfoundland, July 12, 1965.

PARAPLEGIC UNIT . . .

Six Big Steps to Recovery

At 20 he was strong, healthy and vigorous. His schooling was behind him; the world was his to conquer.

Then on a November night, just before his 21st birthday, all his dreams were shattered. He was involved in a car accident and in one flashing second Robert X became a quadriplegic, paralysed almost completely from about the shoulders down. Control of his normal body functions was lost, together with most forms of feeling and awareness of his body.

What happened to Robert X befalls many Canadians every year. A bullet wound, a fall, a diving accident, a tumour or any other spinal cord injury from accident or disease may cause the conditions known as paraplegia (paralysis of the legs and part of the trunk) or quadriplegia (paralysis of all four limbs and the trunk muscles). And strange as it may seem today, these injuries, less than 30 years ago, were generally considered hopeless. Most patients did not live long enough to necessitate any rehabilitative measures.

It wasn't until after the Second World War that the picture changed. Through the pioneering efforts of such men as Dr. Ludwig Guttmann and Dr. Frank Wild Holdsworth in England, Dr. A. T. Jousse and Dr. Harry Botterell in Canada and others in the United States, it was found that with proper treatment and enough encouragement, the majority of paraplegic patients and many quadriplegics could learn to master the movements necessary to lead independent productive lives. They could, in fact, live out their normal life spans as respected citizens in the community and in many cases carry on a full day's work side-by-side with the completely able.

The first to benefit from these discoveries were, of course, the service men. But in post-

war years more attention was focused on civilian cases, and agencies and individuals sought to establish treatment programs for all types of paraplegic and quadriplegic patients, first in the veterans' hospitals and later in the newly emerging rehabilitation centres. In 1962, therefore, when the Manitoba Rehabilitation Hospital was opened in Winnipeg, a special unit for the treatment of spinal cord injuries became a natural and important part of the hospital's facilities. With the assistance of the Canadian Paraplegic Association and the co-ordinated efforts of doctors, rehabilitation nurses, therapists, social workers and counsellors, a program was worked out to meet the needs of patients in several important areas. It included an intensive physical development program with accommodation for 15 in-patients at any one time, a full range of out-patient services, a 24-hour emergency service and the provision of self-help devices and medical supplies.

Over the past two years several score men and women from all over the province have been helped back to self-sufficient lives through the enthusiastic efforts of the rehabilitation staff. The biggest challenge, according to the unit's medical director Dr. Basil J. S. Grogono, is to provide the proper motivation; to encourage and spur on each patient to meet the series of difficult hurdles the rehabilitation program presents.

It is also important, staff members stress, that treatment begin as soon as possible in the rehabilitation hospital. If patients are held initially in hospitals not staffed with special spinal injury teams, much valuable time may be lost trying to correct such complications as pressure sores, muscle atrophy and contracture and bladder problems.¹ Expert nursing in the early stages



Treatment begins when the patient is still in bed and unable to sit up. Physiotherapist Mrs. June Rankin-Wilson assists this patient to do active and passive exercises to maintain muscle strength and prevent stiffness of the muscles and joints.



Following the initial bed phase, the patient begins treatment right in the physiotherapy and occupational therapy departments. This patient with quadriplegia does pulley exercises to strengthen his upper limbs.

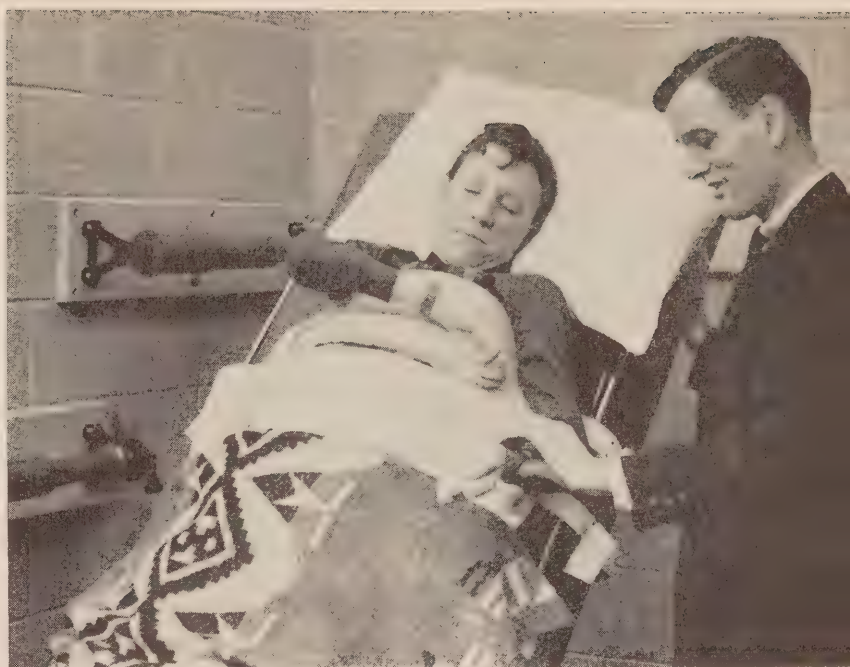


ambulation is acquired slowly. First the patient practices balancing on mats, then between parallel bars and finally graduates to walking with crutches, braces, or both. These patients, with incomplete cord lesions, do graduated walking exercises in the small gymnasium.

A patient with incomplete quadriplegia puts pegs in holes to improve the accuracy and control of his fingers and hands. Traumatic accidents account for most paraplegia and quadriplegia, but the conditions may also be caused by tumours, congenital defects or diseases.



Dr. B. J. S. Grogono, an orthopaedic surgeon in charge of the paraplegic unit at the Manitoba Rehabilitation Hospital, checks the pulse of a quadriplegic patient who has been placed on a tilt table. The table is used for metabolic purposes and it helps the patient to become accustomed to the upright position. Many quadriplegic patients suffer from dizziness and blackouts when moved towards an upright position during these early stages, owing to changes in their blood pressure. The angle of tilt is gradually increased until the patient can tolerate the vertical position for a reasonable period.



A paraplegic patient uses a mobile unit for locomotion during certain periods when he is restricted from the use of the wheelchair.



Special splints, such as this wrist-driven flexor hinge splint, have been devised to help the quadriplegic patient grasp things. The development of electronic equipment, better braces and surgical procedures are also improving the lot of the severely disabled.

plays a major role in the prevention of such complications.

At the Manitoba Rehabilitation Hospital, therefore, the training program for new patients begins, if possible, while they are still in the acute stage. The program comprises six stages in all, beginning with treatment on the wards and progressing to more and more activity in the physiotherapy and occupational therapy departments as the patients regain physical function. The paraplegic patient, for example, must first learn to turn over in bed, then sit up and maintain balance. Next he learns to transfer in and out of a wheelchair and to manoeuvre the wheelchair so that he may take his meals in the cafeteria with other patients and start his program of exercises in the gymnasium and pool and in the occupational therapy department. From the very beginning he is taught to master the activities of normal daily living. Throughout his hospital stay, agencies such as the Canadian Paraplegic Association work closely with the hospital staff first to assist the patient in the psychological adjustment to his disability and later to get him trained for employment and established in the community.

The treatment goal and length of hospitalization depend on the location and severity of the lesion. If the spinal cord is completely severed or extensively bruised, the parts of the body below the injury are separated from their connection with the brain and there is total paralysis below the injury. If, however, the cord is not divided entirely, the strength and sensation in the parts of the body below the injury may not be wholly lost. A partial lesion in the lower or lumbar region of the spine, for example, could mean that the patient will walk again, with or without special aids. A complete lesion at the fifth or sixth segment of the cervical or neck vertebrae will mean only limited mobility. The patient may be able to perform some dressing and bathing activities, feed himself by means of special appliances and wheel his wheelchair.

Thus it is seen that injuries to the spinal column between these two regions will result in varying degrees of disability and different treatment goals. The treatment goal for Robert

X, for example, is to make him as independent as possible in his wheelchair. Now at Stage Two of his rehabilitation program, he is doing exercises to strengthen the muscles he has left and to keep the joints mobile. Through these exercises he will over-develop the unaffected muscles of his shoulders and arms, and strengthen, if possible, the few unaffected muscles remaining in his hands. It will probably take eight months or more before he attains the program aims. A paraplegic patient with less severe injury, on the other hand, would probably reach his treatment goal in a much shorter time.

Re-establishing the paraplegic or quadriplegic patient in his home, community and at work is the final step towards successful rehabilitation. Towards the end of his hospital stay, the therapists will often accompany him outside the hospital so that he may learn to cope with "real" situations. Getting on and off a bus, transferring from a wheelchair to a seat in the theatre, negotiating curbs and revolving doors and handling crowds present far different problems than those encountered in the staged situations in hospital, and all these challenges must be met and overcome if the patient is to live a full and happy life.

Training and employment are other big problems. The greater percentage of paraplegics and quadriplegics require further schooling and training to obtain the special skills they will need to compete successfully in the employment market. Training schools such as the Manitoba Institute of Technology will accept wheelchair students, but in order to get them started in this direction as soon as possible, both the hospital staff and the Canadian Paraplegic Association hope to establish an education program for patients while they are still under treatment.

Just how successful is the program for these patients? In a review of 309 cases who have received substantial rehabilitation services in Manitoba over the past 20 years, the Canadian Paraplegic Association has come up with these interesting facts. Excluding those still under treatment or in training, says the association, 142 out of 252, or 56 per cent, have found employment in a great range of trades and professions.

The record for paraplegics is 55 per cent, for quadriplegics, 37 per cent and for polio cases, with problems and paralysis related to paraplegia, 78 per cent. Almost all of those who completed vocational training course, the association noted, are now employed.

Of the 309 cases, 129 own their own homes, 26 others live in rented homes or suites, 20 live in boarding homes, 53 live with their families and only 14 are in institutions. A total of 258 are either totally confined to a wheelchair or are performing most of their activities from a wheelchair. The remainder are ambulant in varying degrees. More than half are married. And a substantial number drive their own cars, which is considered a significant factor in getting the paraplegic out into the world again and back to remunerative employment.

It isn't easy for paraplegics and quadriplegics to attain their rehabilitation goals. The greater the physical involvement, the harder they must strive, the more persistence and courage they must have. But these statistics are proof that such patients *can* work at income-producing jobs, or, should this be physically impossible, they can at least reach the point where they are able to return to their homes and families instead of being confined to hospitals and institutions.

Though the road back is difficult, the world is still theirs to conquer — even if it must be from a wheelchair.

¹ At Stoke-Mandeville Spinal Injuries Centre, England, and at the West Australia Spinal Injuries Centre at Perth, patients are transferred (by plane, if necessary,) to the centres immediately following injury.

From Sanatorium Board of Manitoba News Bulletin, April, 1965 issue.

Housing and Special Accommodation for the Physically Handicapped

BY A. T. MANN

With the campaign against architectural barriers well on its way, the committee on Building Standards for the Handicapped is taking a look at two additional aspects which are closely related to this problem and have a direct impact on the life of every disabled person — residential accommodation and community planning. On June 28th, a sub-committee met at the NRC Building in Ottawa to consider the first draft of what it is hoped will be a follow-up document to Supplement No. 7 of the National Building Code.

Considered in the draft were specifications for both private homes and apartment type units. These specifications are being set down on the basis of minimum requirements and the kind of modifications which would be necessary to make existing Central Mortgage and Housing Corporation plans suitable for use by the disabled. Such things as type of kitchen, bathroom layout, size of hallways, window hardware, garage space, and so forth, will be included.

Without going into specific detail, the draft also comments on facilities in schools, churches, hotels, theatres, restaurants, railroad stations, bus and air terminals, public parks, community clubs and other facilities which are a part of community life.

This is, in itself, a fairly ambitious undertaking, but more important than the physical requirements of such accommodation was the fact that in working with representatives of the Central Mortgage and Housing Corporation, committee members were encouraged by the acceptance of the basic philosophy that disabled people have the right to expect a decent place to live, at a cost that they can afford to pay. If the note of optimism which prevailed at this initial meeting can be sustained, the provision of housing for the disabled will be assured.

Extract from "Paratracks" July 1965.

The Mental Retardate - His Problems and Actions

BY JOHN D. COX

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What special problems has the retarded person which differ from the problems of the rest of us? How does the behaviour of a retardate differ from ours? In all honesty I see little difference except that being retarded makes life's hurdles more numerous and more difficult to surmount. Restrictions loom at every turn.

Thus the retardate has daily to face and overcome situations which his less handicapped brother barely notices. His frustrations are more numerous just because he is not as intellectually able as the rest of us.

The retardate's reasoning powers are limited and he finds abstract concepts extremely difficult to grasp. New learning is tedious and he easily forgets.

Usually he cannot perform as adroitly with his limbs and hand-eye co-ordination is often limited to fumbling.

His speech often lacks fluency and good diction, making communication of even very meaningful wishes and thoughts cumbersome. This often leads to misunderstanding.

In language he not only experiences the motor difficulties of articulation but he has trouble in gaining an intelligent understanding of what he hears. The meaning of even important and simple words are often misunderstood. Coupled with this he has to grapple with words strung together into thought pictures foreign to him.

Imagine for a moment how you would feel if you were suddenly transported to a foreign land where language and customs were totally different from what you were used to. Everyday communication and even very commonplace sights, sounds, and social order would bewilder you.

You would be faced with an immense task of adaptation, despite your normal intelligence.

It must be not too unlike this for the retardate placed in our society, where even in our schools and in our workshops standards still largely cater to those of average background experience and intellect.

The retardate must also learn by observation and association when these very abilities are inhibited. Laborious experience, often repeated with many, many mistakes, is necessary not only to communicate but to perform even the most simple socially accepted tasks.

Perhaps the most useful contribution the retardate makes to society at large is to act as a sensitive sound board for the society in which he lives. From him we can learn acceptance, tolerance, compassion and love. By our striving for his sake we learn more understanding of all human behaviour. It is a fact that many of the important advances in education have been brought about by those educationalists and doctors who have had an unusual interest in the retarded, striving to find some means of training and educating them. The concepts that they have developed have been utilized by teachers having the management of the "average" child. Their efforts have brought about a greater understanding of childhood behaviour, the learning process and methods by which we can educate children.

It is probably more necessary to educate the community to accept the retardate than for him to understand and accept our standards. For unless the community shows genuine acceptance and understanding of him and give him the consideration which is his right the retardate cannot

hope to achieve success and a sense of worth.

Education of the retardate has evolved from the feeling that nothing can be done except to shut him from our sight through the stage of frustrated but sincere attempts to cater to his needs to the present realization that education must lead to satisfying self-determination. We now believe that education and training must be offered and freely given so that the retarded can utilize their assets and capitalize on their strengths in order to be able to live as bountiful, self-satisfying and useful lives as possible — to their greater benefit and ours.

The frustrations which the retardate faces because of his limited intellect probably bother him less than his parents, instructors and those others dealing with him. His limited intelligence offers a sort of built-in safeguard provided our expectations do not point up to him his shortcomings to such an extent as to produce anxiety. Handicaps are more a concept of society than inherent limitations.

It is our reaction to the retarded which in large part determines their acceptance of their limitations. To my mind the retardate is much more like us than he is different from us and with our genuine, realistic acceptance of him, he, too, can live a happy, useful life.

The retardate too needs success — success when achievement often seems impossible. He, too, needs to feel secure, wanted and respected and to feel that he has a place which is valuable in the eyes of others and which brings him a sense of well-being and achievement.

The retardate, as anyone else, needs to be treated as a whole person, for unless his self-image can be built up so that he feels good about himself all the amount of training, all the programming in the world will be of little avail. Our emotional health, whether we are bright, average or retarded, is an essential prerequisite to successful living. This is proved time and time again in the classroom, in the workshop, in actual job situations and in every phase of community living. We lose jobs not because we do not know how to perform them efficiently — for we can be re-trained or a new position can be found — we lose jobs because we don't feel secure in ourselves

and do not have a good self-image or because we cannot get along with other people.

I think it is up to those who are not retarded to be quite sure they do not lump together retardation and stupidity, retardation and criminal tendencies, retardation and plain bad humour. The retardate is no special species, he is a human being first with the same needs and similar possibilities for good or evil as the rest of us. He should not be set apart from society but by concentrating on his strengths rather than his weaknesses we should utilize his abilities, however limited, so that he may have as full a measure of self-realization as his abilities allow.

It is often claimed that the retardate is easily led into keeping bad company and into doing anti-social acts. Even supposing there is some truth in this statement it seems to me that any such tendency there might be with some individuals is the result of not foreseeing the consequences of actions coupled with the fact that the retardate often finds it extremely difficult to achieve success and approbation by the usually accepted channels. I doubt that it indicates a general tendency of the retardate to anti-social behaviour. In other words it is how society views the retardate, accepts him and what provisions are made for ensuring he has some measure of worthwhile achievement and knows he is accepted. This applies particularly to slow learners and to the educable retarded who seem to find the pressures of society greater than those more retarded.

Certain anti-social acts may be brought about by misguided motives — as with the older retardate accused of kidnapping a small child when in fact it appears he just felt sorry for a lonely child and took him into his meagre apartment to live. I know for sure that if I were exposed to as much frustration every day as a retardate I would likely react more negatively than he does.

As far as the retardate's actions in the workshop are concerned we must recognize his limitations which include greater difficulty in learning, less innate awareness of the consequences of his actions and less social sense. How then shall we treat the retardate in our workshops? To mollycoddle or to demand impossible standards?

The retardate needs to be treated as a normal human being with specific limitations necessitat-

ing more supervision and more patient guidance, fewer generalities and more specific instruction in each small phase of each particular job. He needs controls to give him a sense of security and he needs standards he can be proud of achieving.

There must be an adequate appraisal of the retardate's strengths and weaknesses, for this leads towards understanding of him and his problems and the acceptance of him with his limitations.

We need to assess the individual retardate — assess him realistically on the job — how does he function — how does he behave under seemingly optimum conditions — how does he react under pressure — what are his limitations and his strengths. What is his staying power, his initiative, his co-ordination. How well does he get along with others? What can be done to help him function more effectively and improve his self-concept?

The retardate learns by association and by repetition, not necessarily by repeating the same task but by performing similar tasks. The retardate learns by copying the examples of others and it is essential that the examples set by instructors, both as far as work procedures and habits are concerned and as far as attitude and general demeanour, are of the highest order.

Experience has shown that the retarded respond more readily to an emotional appeal than through their intellect. In other words they can be reached through the heart rather than through the head.

The important issue centres on whether or not the retardate is accepted as a human individual with a personality unique to him; a creature of God with a certain right to inner happiness and self-fulfilment, though possessed of limited intellectual ability. Always stress the assets not the liabilities.

Objectivity with compassionate understanding is necessary. While you should not hesitate to call on proper professional advice you should never forget that patient understanding and objective observation are invaluable on the job, to proper assessment and training. Deep psychiatric counselling should be left to the professional psychiatrist, psychologist and social worker. Nevertheless it will be necessary for instructors or directors of workshops to counsel trainees and help them overcome their day to day frustrations,

clashes with other trainees and instructors and to help them work through the inter-personal conflicts which are bound to exist in any training or work situation. Usually a very common-sense approach with the counsellor listening and trying to be as objective as possible while showing sympathy and strict fairness works wonders.

Should workshop trainees use potentially dangerous equipment — such as punch presses, electric saws, etc.? Generalization here is dangerous and can only serve as a guide for, in the last analysis, it depends on whom you are dealing with, what kind and quality of supervision obtains, what are the built-in safeguards, the nature and quality of the program and the particular tasks involved. To ask the retarded to perform too many complicated sequences is usually unrealistic.

I have never heard of a workshop trainee who seriously injured himself on machinery yet I have heard of instructors so doing. This I have found true both in the workshops in Ontario and at the Slough Project in England. There may be several good reasons for this — sound supervision — well planned units of work with adequate safety devices and proper jigs and, I like to think, the retardate is often absorbed in the task to hand and is not as easily distracted by extraneous thoughts of home, girl friends, etc., which beset the rest of us and lead to carelessness.

What program, what level of supervision, what structural controls you should have in your workshop depends not only on those who administer the program but on the types of trainees, the facilities available, the expectations of the community and the type of contracts which are obtained.

Whatever the program it should be recognized that, as with young children and even teenagers, certain standards, certain limitations, certain structures are essential to providing boundaries and a framework for action.

The retardate responds to respect and trust — this embodies responsibility — responsibility within the context of his limitations and the program. You must demonstrate positively that you trust the retardate and give him that measure of responsibility your judgment tells you he can handle. Maturation with any person, whatever their level of intelligence, embraces growth towards independence, both in work and social behaviour.

Harold Russell Speaks on Employment of the Handicapped

Extracts from the address of the Chairman of the President's Committee on Employment of the Handicapped during a recent visit to Canada.

"We never have, and we never will, ask employers to hire the handicapped out of a sense of charity. We don't want that and the handicapped don't want that. Instead we ask simple justice and simple common sense.

I think I can best tell you about the handicapped in general by telling you the stories of three handicapped people in specific. They dramatize the whole meaning of opportunity for the handicapped.

I have in mind a brilliant young electronics engineer on the West Coast who supervises a staff of researchers. He is the author of many

papers, the holder of many patents. To listen to him, you know you are face-to-face with a genius. He is in a wheelchair. He is so completely paralyzed by polio that he can barely feed himself. Someone else has to hold the books and memos he has to read; he can't handle them himself.

Do you know what this man does when he goes home at night? He doesn't do what you and I do; have a nice dinner and relax by the TV set or with our circle of friends. He gets into an iron lung at night. And he stays there until the following morning. That's why he is alive today.

Handicapped? Physically, yes; but in terms of ability, a definite NO.



Mr. Russell visited the Workmen's Compensation Board Hospital and Rehabilitation Centre, Downsview, Ontario, on August 12, 1965. Left to right: Harry Worling, Chief Rehabilitation Officer, WCB, Mr. Russell, Dr. A. Kennard, Physical Medicine Consultant, WCB, and Ian Campbell, National Co-ordinator, Civilian Rehabilitation.

I also have in mind an employee in a shoe factory in Pennsylvania. He happens to be mentally retarded, so much so that he has never learned to read or write. His job is to take a strip of leather, place it into a metal jig, insert a couple of tacks — and presto, it comes out a neat bow for women's shoes. It's a routine job, performing the same operation hundreds of times every day. You and I wouldn't like it. But this job is his life; he reached upward for it, and he is proud of it.

Now, the shoe factory spent some \$300 to develop the metal jig. This young man used it a while, but found it wasn't accurate enough. The leather slipped. And so he took a slab of wood, 24 cents worth of nails and thumb tacks, and built himself another jig far more accurate than the one costing \$300. That's the one he's using now.

Handicapped? Mentally, yes; but in terms of ingenuity, not at all . . . !

Now these people — and millions more like them — wear the tag 'handicapped'. Is that the right tag? Are they really handicapped on the job?

I think not. Their handicaps haven't kept them from functioning. They are earning every penny of their pay. They are brilliant successes. . . . Although they may be physically handicapped, or mentally handicapped, they are NOT vocationally handicapped. And that's what counts. They are NOT vocationally handicapped.

There you have an important distinction — one that makes all the difference between job equality or job inequality for the handicapped. The big question is: what kind of handicap? A physical or mental handicap shouldn't keep a man or woman from working; but a vocational handicap might.

There's one more thing to keep in mind in considering the handicapped.

Basically, the handicapped are no different from anybody else. They are human beings with the full range of human talents — a fact that some people seem to forget. But because they are handicapped, many of them try harder. Many have that extra-special motivation that drives them to success. Psychologists call it 'compensation' — when you lose the function of one part of your body, you tend to make up for it by developing your unimpaired faculties. You do try harder.

And so the handicapped have had more than their share of successes on the job. Here are some of the facts of the matter:

A vast survey by the Department of Labor, in the United States, showed that the handicapped have a five per cent better safety record than the able-bodied, and even out-produce the able-bodied. . . . !

Another survey of employers by Prentice-Hall Publishing Company showed that the handicapped ranked higher than the able-bodied in job safety, in job stability, in morale, in ability to get along with fellow-workers. . . . !

The du Pont Company studied the records of 1,000 handicapped employees, and found that they generally ranked above the able-bodied in production, attendance and safety.

The U.S. Chamber of Commerce and the National Association of Manufacturers made a study of 279 businesses, and learned that the handicapped had superior safety records and superior attendance records.

All of which boils down to this: The handicapped have abilities and they have motivation. All they need is the chance to prove it — the same chance anybody else would have. You can be proud to speak out in their behalf."

HIRE THE HANDICAPPED

Helpful Hints for Supervisors

The International Management Seminar on Job Re-design and Occupational Training for Older Workers was arranged by the Organization for Economic Co-operation and Development (OECD) and held in London in the fall of 1964. Papers presented at the Seminar show that researchers have developed effective techniques for training older workers and that these methods have been successfully applied for different types of workers in various countries.

The paper which follows was presented at the Seminar. It is reproduced in its entirety because of its interest to those persons in the field of rehabilitation who are directly concerned with the training of the handicapped, many of whom are older persons. The principles it outlines could apply to all types of training.

Training Older Workers in New Skills

BY PROFESSOR L. WILLIAMS

*New York State School of Industrial and Labor
Relations, Cornell University*

An accounts-receivable department converts its operations to electronic equipment.

A former textile worker applies for an assembly-line job in an appliance plant.

After 22 years as a pattern maker for an oil refinery, an employee is switched to the job of operator in an automated refining unit.

All these situations present a problem that is becoming more and more frequent with the spread of automation: the retraining of older workers.

For the supervisor who is dealing with it now — or will be soon — awareness of its special problems may make the difference between success or failure in developing a productive employee.

A supervisor may assume that because an older trainee (and by older, in this article, we mean any trainee who has had long experience in some other type of work and is substantially older than the other trainees in his group) doesn't seem to be making the grade, he is incapable of learning new skills. This is rarely the case.

Learning and "unlearning"

Although an older person may learn more slowly than a younger one — for one reason, he must unlearn old habits and skills as well as learn new ones — he nevertheless may retain

what he learns better than the younger ones. His experience enables him to select the important elements of a lesson and to grasp principles that make it easier to absorb procedures that are new.

Inability to learn, then, is usually not why an older worker may find it difficult to take his retraining in stride as easily as younger workers undergoing the same training. The trouble often lies elsewhere. Let's take, for example, the situation of the veteran pattern maker in the oil refinery, mentioned earlier. As a skilled worker for 22 years, he gained plenty of status in his department. Younger workers came to him for advice. He had independence — because of his seniority and his reliability, he needed very little guidance from his supervisor. His long tenure on the job gave him status with his family and his neighbours, too.

Now all that is being stripped away from him. His pattern-making skills are no longer needed by his company. But rather than give up a valuable employee, the company is retraining him to be a refining unit operator in a new, automated setup.

His prospects may be good. But the fact that looms largest in his mind is that he is back where he was 22 years ago — a green trainee. To regain his former status, he must start the whole tedious climb up the ladder again. More-

over, he worries because the younger trainees alongside him are learning more quickly than he can. Even the people training him are younger than he is.

He also has re-adjustment problems off the job. Although he's only a raw trainee in the plant, off the job he is a husband, a father, a P.T.A. member, a Boy Scout leader. His family can't seem to understand why he must go back to the trainee level again. This disapproval is one more worry that prevents him from doing his best.

Time is another thing he must give up. He long ago established a pattern of leisure activities, which must now be changed. To keep up with the younger trainees he spends much of his free time studying. Because he is reluctant to admit this to anyone, he assumes that he is the only one who has to burn the midnight oil to get his assignments done.

All these are real problems to the older trainee, and the supervisor should treat them that way. That doesn't mean he should overdo his sympathy to the point where it produces self-pity rather than a determination to work things out. The primary responsibility for overcoming the adjustment problems rests with the trainee himself.

But there are useful steps the supervisor can take to help him. In scheduling the training sessions, for example, try to avoid having one older trainee isolated in a group of younger ones. Putting a few older trainees in the group gives them a chance to share their problems. Each will find out, for instance, that he's not the only one who has to study late, and his task won't seem so tough.

Although a supervisor should never talk down to any trainee, he should be particularly careful about this when training an older worker. The supervisor who shows his awareness of the trainee's former status will find him much more co-operative and willing to learn.

Reassure him

A supervisor can also encourage the trainee by reminding him often that he will soon be a valuable, functioning employee again. With his eyes on the future, he can retain his feeling of

self-respect and adjust more easily to his present status. Moreover, this kind of motivation can greatly increase his learning proficiency.

The older trainee should be reassured that the speed with which he learns the new skills is not so important as how well he learns them. Within reason, he should be allowed necessary extra time to absorb the new assignments.

Long-time habits that a worker carries over from his old job may interfere with his learning the new one. The supervisor should find out as much as possible about the trainee's old job, and watch for habits that retard learning. He must keep an eye out for any back-sliding into old habits after a new skill has been learned.

If a supervisor isn't sure what's bothering an older trainee, a sympathetic talk — in private — may help to bring out his problems so that ways of dealing with them can be discussed.

The payoff

Is helping an older trainee just altruism? Most certainly not. Once he is successfully launched on his new job, he may very well be a more valuable employee than many of his younger co-workers. Experience with older workers has convinced many companies that they are often superior in these respects.

1. They are more stable, less susceptible to outside distractions.
2. Their maturity makes them more conscientious — so they turn out higher quality work.
3. They try harder because they often have more at stake than the younger man.
4. They tend to be more cautious and have fewer accidents.
5. They are likely to have better over-all absenteeism records.
6. They create less turnover.
7. They often display sounder judgment than younger workers.

It all adds up to this: While the supervisor faces special problems in training the older workers, these problems are well worth an attempt to overcome them — the payoff will often be a superior employee.

Special Services Rehabilitation Unit

A report of the second year's operation of a project designed to demonstrate the role of a vocational rehabilitation program in re-establishing chronic welfare dependants.

In the light of the first year's experience (see "Rehabilitation in Canada" Fall-Winter 1964-65, page 13) some distinctive new steps were taken in 1964. Instead of confining or isolating chronic welfare dependants into a separate physical unit, as in the previous year, they were integrated into the total group of persons being served in the Vocational Rehabilitation Centre. This group was made up largely of convalescent mental patients. The total group was divided into three workshop units each with distinctive goals and work atmosphere.

The first unit, comprising 20 trainees, is characterized by a relatively slow pace of production, benign and supportive supervision, and an atmosphere fairly free, although not completely so, of competition and tension.

The second unit, also accommodating 20 persons, maintains a more demanding production schedule, more authoritarian supervision and an expectation of work performance which is comparable to that of a normal industrial situation.

A third unit, limited to 10, provides intensive care for individuals who appear to have relatively low potential for rehabilitation. These persons require frequent daily personal attention and their participation in the other units would be detrimental to their progress and demoralizing to others moving through the rehabilitation process.

Clients are assigned to and are moved from one unit to another depending upon their needs, their progress and the clinical goals established by the professional staff of the centre. Most of them remain in the program for 12 weeks or less. The first three weeks are designed for basic

assessment purposes and the following nine are for work adjustment training and preparation for employment. In a small number of cases trainees are permitted to remain in the program for up to 12 months provided there is sufficient progress towards employability. In such cases there is a complete review and assessment of their status on a quarterly basis.

This reorganized system has proven beneficial and effective in meeting the individual requirements of each client. The availability of units with different work atmospheres and goals enables the staff of the Centre to respond more adequately to the handicapped person rather than to a label associated with him (e.g. chronic dependant, convalescent mental patient, etc.) which tends to blur his identity as a distinctive individual.

It must be emphasized that, while chronic welfare dependants are no longer isolated in a separate workshop, the special rehabilitation effort conceived for them continues but in a new and more dynamic atmosphere.

Increase in Service

There has been a consistent increase in the number of chronic dependants referred for rehabilitation services over the past three years and also an increase in the community agencies who have made referrals to the program.

Interesting Results

During the year 154 persons were separated from the project of whom 60 were chronic dependants. These persons have now been out of the workshop for from three to 15 months and

follow-up shows that sixty per cent achieved employment or are making significant strides towards achieving such a status; seven per cent became ill after becoming employed and eight per cent failed to meet job standards after placement. The remainder either withdrew before completing the program or were judged to be unemployable.

Casework Assistance Provided

To correct a gap encountered during the first year of the program arrangements were made with the Rehabilitation Service Branch, (Federal-Provincial Rehabilitation Program) Ontario Department of Public Welfare, to provide intensive casework for chronic dependants referred by those agencies which did not have personnel to provide such services themselves.

Steps to Prevent Dependency Explored

The intake policy was modified to make

service available to individuals who, though young or new to welfare agency caseloads, displayed attributes associated with chronic dependency such as low motivation, resistance to change in their patterns of behaviour, fear of responsibility, readiness to rely upon others for the basic amenities of life, inadequate preparation for employment, failure in job adjustment, and so forth. Officials of several junior vocational schools have expressed interest in the applicability of this type of program to selected students who are adjusting poorly in school or who seem headed for maladjustment and dependency after separation from school. This whole area of prevention in relation to dependency requires study. It may be that broader application of rehabilitation concepts such as those being tried out in this special program will lead to important break-throughs in the projected "war" on poverty and dependency.

People and Events

Reader's Digest Award Presented

The Bio-Engineering Institute of the University of New Brunswick and the Ontario Crippled Children's Centre in Toronto were joint recipients of the Reader's Digest third annual award for outstanding service in the field of rehabilitation. The presentation was made at the annual dinner of the Rehabilitation Council for the Disabled held at the King Edward Hotel in Toronto on October 22.

Accepting the commemorative plaque for the Institute were Professor R. N. Scott, its executive director, and author of the article on page 4 of this bulletin, and Mr. Dow S. Dorcas, Research Associate of the University of New Brunswick. Recipients of the second plaque were Colin McLaurin, Project Director, Prosthetic Research and Training Unit, Ontario Crippled Children's Centre, and Mr. R. J. Telford of Dixie, Ontario, representing the Ontario Easter Seal Society.

Commenting on the 1965 award, Dr. Keith S. Armstrong, Executive Director of the Rehabilitation Council, said, "By honouring the University

of New Brunswick and the Ontario Crippled Children's Centre, the Reader's Digest has acknowledged the pioneering work done by these two organizations in the field of prosthetic research. Though thousands of miles apart geographically, these two organizations have worked together combining the electrical arm prostheses of the Ontario Centre with the myo-electric control system developed in Fredericton by Professor Scott and his associates."

In the citation accompanying the award, mention was made of the fact that, though scientists and medical personnel in the U.S.S.R. had utilized a control principle in fitting a large number of adult below-the-elbow amputation patients, it remained for the University of New Brunswick team to develop a control system that would be suitable for the weaker signals from the muscles of a limb-deficient child. Not only was this accomplished but in so doing the New Brunswick researchers produced a two-step control whereby a single muscle can do the work of two.

The \$500 cheque, which accompanies the award, will be shared by the University of New Brunswick and the Crippled Children's Centre.

Canadian Hearing Society

The annual report of the Canadian Hearing Society shows an expansion of services during the past year which enabled more than 4,000 persons with impaired hearing to receive help of one kind or another. In the same period, 234 deaf people and 79 hard of hearing found employment through the efforts of the Society's employment officers.

In 1964, the Society experimented with a program of sending its employment officers on periodic visits to schools for the deaf. Previously they had visited the schools for two or three days in March and again in May, but the experiment has shown such promise that it will be continued.

The Society also assisted in planning which enabled a number of deaf students to take advantage of Federal-Provincial Vocational Rehabilitation assistance in the form of training at Galaudet College in Washington.

Ben Parks Training Centre Opened

On September 30, the new Ben Parks Training Centre of the Society for Crippled Civilians in Toronto was officially opened. The ribbon-cutting ceremony was performed by Miss Joanne O'Hanley, herself a cerebral palsy victim and a trainee at the centre. The reason for selection of this young lady is best expressed in the inscription on the stainless steel plaque which was unveiled during the dedication ceremony by the

Honourable W. Earl Rowe, Lieutenant-Governor of Ontario. It reads: "Officially opened by Joanne O'Hanley who, because of her cheerful acceptance of her disability and determination to help herself, is representative of the community handicapped and disabled to whom the Society dedicates its efforts and services."

The Society for Crippled Civilians has been operating a sheltered workshop and training centre on Duke Street. The addition of this three storey training centre round the corner but adjacent to the original centre will add much needed space for an enlarged program.

The Society for Crippled Civilians operates the largest workshop in Canada giving work and training to over 300 persons daily.

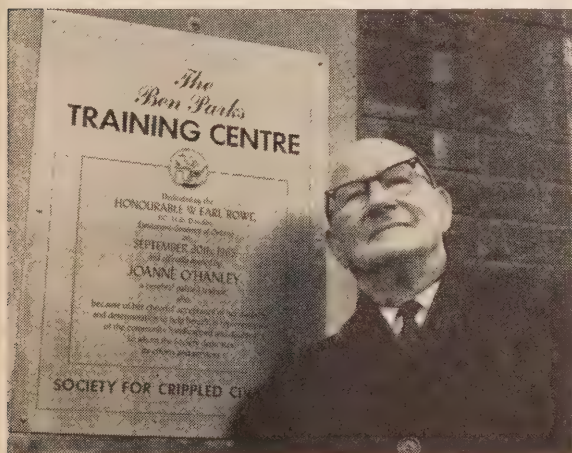
The new centre was named in honour of the man who: "guided the Society for a quarter of a century through some of its most difficult periods; who conceived and put into effect many of its basic programs and policies and whose vision concerning the handicapped's merits and needs encompassed the full spectrum of community effort," as W. Struan Robertson, Q.C., said in paying tribute to Mr. Parks during the ceremonies.

Is Rehabilitation Worth While?

About two years ago a newspaper carried an account of a young man surrendering himself to the RCMP after being hunted for a considerable length of time for several offences. Casual reference was made to the fact that the elusive fellow had a physical disability.

On reading this, a rehabilitation counsellor felt that anyone smart enough to elude the RCMP should be encouraged to direct his energy and ingenuity into constructive channels. The young man, who suffered from a tubercular-arthritic hip, was contacted through local police authorities and with their co-operation and that of the National Parole Board, was allowed to receive vocational training.

Under Program 6 of the Vocational Training Agreement he was trained in watch repairs and this, coupled with some previous experience in radio and television repairs, enabled him to open a small business. By March 1965 he was doing well enough to take on extra help and, perhaps



Mr. Parks outside the new training centre.

remembering his own difficulties, chose a person who was handicapped by impaired vision; had also been in trouble with the law; and had some training in appliance repairs.

At last report, business was steadily increasing and both were fully occupied. It could be said that with their debt to society paid and their handicaps overcome they have been doubly rehabilitated.

Annual Conference

"Searching — Seeking" was the theme of the Eighth National Conference on Mental Retardation held in Saskatoon, Saskatchewan. The conference, sponsored by the Canadian Association for Retarded Children, was attended by some 450 delegates from across Canada.

Sessions for general delegates and special study groups were included in the three-day program and dealt with all aspects of Association work from Adult Services to Religious Education and touched on areas of activity of the newly launched National Crusade for Canada's Mentally Retarded.

One of the highlights of the conference was the address of Robert Jacques, president of the Association. In his remarks Mr. Jacques stated that although the cause of the mentally retarded had reached new heights, there was still a long way to go — only a good beginning had been made.

"It has been a busy year — an exciting year," he said, "one in which there has been significant progress and one in which we have seen the foundation laid for even more dramatic advances in the near future."

New Vocation for the Blind

A new five-month course to train blind persons as computer programmers has been set up at the University of Manitoba. Four students have already completed the course and three have found employment through the efforts of CNIB employment officers who located the positions and convinced the management that blind computer programmers could do a satisfactory job.

Six students have enrolled in the second course which is now in progress.

International Goodwill

Industrias Kaiser Argentina has for some time employed blind personnel to assemble very intricate wiring harnesses for the firm's line of vehicles.

It came to the attention of a number of Kaiser people in the United States that these blind workers were in need of Braille watches. Through voluntary donations the watches were procured and despatched to the workers in Cordoba.

Each donor has since received a letter of appreciation and a unique and colourful pennant showing clasped hands and bearing the legend which translated proclaims "Flag of Friendship from the Blind Personnel of Industrias Kaiser Argentina."

Special Guides for Expo 67

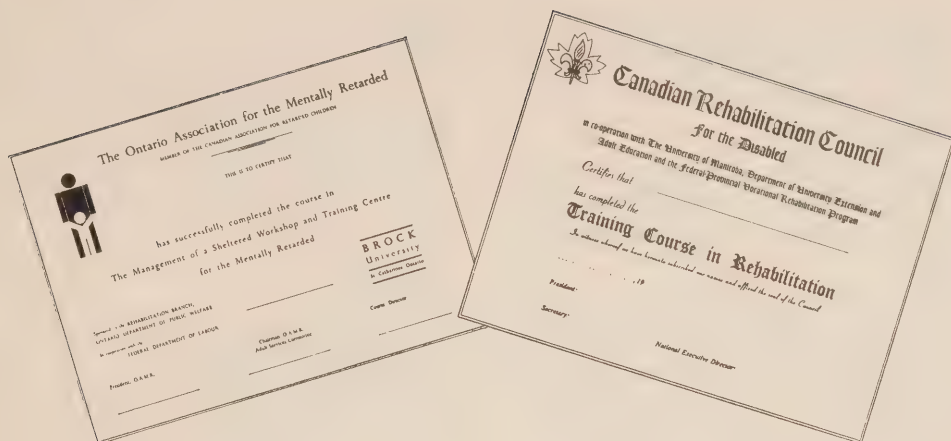
Robert F. Shaw, Deputy Commissioner-General of the Canadian Corporation for the 1967 World Exhibition, officially opened White Cane Week in 1965 and outlined the Corporation's plans to meet the special needs of the blind and other handicapped visitors to Expo 67.

"We have given careful consideration to the needs of blind visitors," he said, "and arrangements are being made in co-operation with the CNIB to give special training to a suitable number of Expo guides to enable them to accompany blind visitors and describe the wonder and excitement of Expo. We are happy to make it possible for these Expo visitors to better 'see' through the eyes of our guides."

Canadian Honoured

Dr. Charles E. MacDonald, superintendent of Jericho Hill School for the deaf and blind in Vancouver, has been awarded an honorary doctorate of letters by Gallaudet College in Washington. This is the only college in the world for the deaf.

The degree was given in recognition of Dr. MacDonald's 45 years of service to the deaf. Dr. MacDonald began his career in working with the handicapped in Halifax in 1920 and has been at Jericho Hill School since 1935.



Training for Rehabilitation Workers

The success of any project is in large measure dependent upon the quality of the staff employed to implement it. Of interest, therefore, are the efforts being made to train workers in the rehabilitation program.

Two highly successful courses have taken place in recent months. The first was held in Winnipeg at the beginning of June and was attended by representatives of eight provinces. During the 17-day course the participants discussed a broad range of subjects including such aspects of rehabilitation as daily living, ambulation, self-help, techniques for evaluating the individual's potential, treatment, therapy and counselling. Specific disabilities such as blindness, cerebral palsy, paraplegia, mental retardation and mental illness were also studied. Throughout the course, which was sponsored by the Canadian Rehabilitation Council for the Disabled and had the co-operation and support of the Federal-

Provincial Vocational Rehabilitation Program and the University of Manitoba, particular emphasis was placed on the vocational training and placement of disabled persons.

The second course was for managers and senior staff of sheltered workshops and training centres for the mentally retarded. Sponsored by the Ontario Association for the Mentally Retarded, it also had the support of federal and provincial rehabilitation authorities. The course was held at Brock University in St. Catharines.

About 40 persons representing over 35 different workshops or training centres in Ontario took advantage of this opportunity to increase their qualifications.

Lectures covered many phases of workshop operation and management; the physical and psychological aspects of mental retardation, social adjustment, assessment evaluation and preparation for employment of workshop clients.

social aspects of rehabilitation and specific disabilities are included. This book contains stimulating and thought-provoking ideas from a broad spectrum of national and cultural backgrounds.

"Disability — Prevention and Rehabilitation" is priced at \$3.50 and may be obtained from: Information Services, International Society for Rehabilitation of the Disabled, 219 East 44th Street, New York, N.Y., 10017, U.S.A.

New Books

Disability - Prevention and Rehabilitation

This is the official proceedings of the Ninth World Congress of the International Society for Rehabilitation of the Disabled which was held in Copenhagen, Denmark in 1963.

Papers dealing with accidents, employment, new rehabilitation programs, congenital defects,

French Talking Books Now Available

The CNIB has made arrangements for the recording of French talking books and some 20 have been released to date.

E. G. Brown, chief librarian, announced the plan to the executive of the Home Teachers' Association at a meeting at CNIB headquarters in the spring.

"Blind persons in almost every province are asking for French talking books as supplements to the records and books in Braille now available," said Mr. Brown. "French is the mother tongue of most of these persons," he added, "although an extraordinary number of blind persons are bilingual."

Quebec and New Brunswick lead in requests for French talking books, although many come from Ontario and Manitoba. Some English-speaking blind persons in these provinces will use the tapes to perfect their English.

"Light in the Kitchen"

A project begun some 20 years ago is now being completed in the service of blind housewives. In the early 1940's when Mrs. E. H. Dickinson was a volunteer canvasser for the CNIB, Toronto campaign, she discovered a need for a cook book in Braille. Mrs. Dickinson collected recipes from outstanding cooks and gourmets throughout North America. Her purpose was to put exotic foods within the reach of blind women.

The recipes are now compiled in "Light in the Kitchen, Cooking for Company" by Marie Dickinson, edited by the Toronto Women's Auxiliary to the CNIB. Compiled in five Braille volumes, printed in "Brailon", a plastic material that may be wiped with a damp cloth, the book will be sent free to any Canadian cook who reads

recipes in Braille and enjoys preparing unusual foods.

If you are a Braille reader and think you qualify, write the CNIB library and order your copy of "Light in the Kitchen".

From — National News of the Blind — Spring 1965.

Film

"Sound the Trumpets"

Copies of the 20-minute colour film "Sound the Trumpets", which portrays the difficulties faced by the handicapped because of architectural barriers in buildings, have been purchased by the Department of Labour and are available for showing to interested organizations.

Produced by the Minnesota Society for Crippled Children and Adults, the film has now been provided with a short prologue which illustrates the Canadian similarity-of-facts and refers to the new Canadian building standards for the handicapped.

Copies of the film are available from the following offices of the National Film Board, to whom enquiries should be addressed:

- St. John's, Nfld.: P.O. Box 1206
- Halifax, N.S.: 1535 Dresden Row
- Montreal, P.Q.: P.O. Box 6100
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